





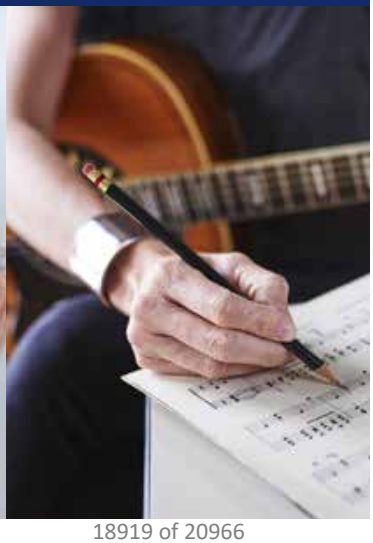


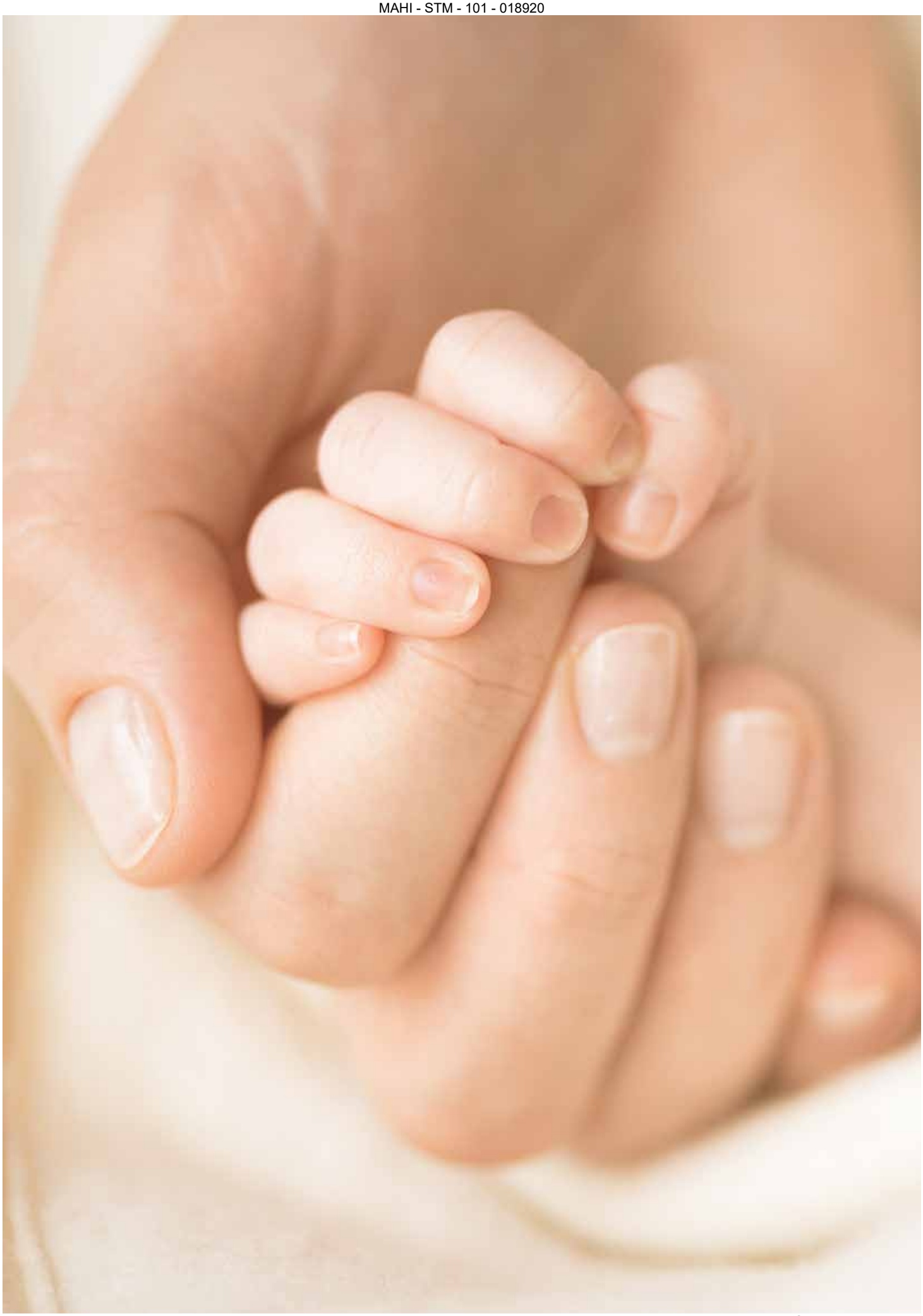
ADVANCED AHP
PRACTICE FRAMEWORK

Guidance for Supporting Advanced Allied Health Professions Practice in Health and Social Care

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk





CONTENTS

Foreword by the Department of Health Permanent Secretary

The Department of Health (DoH) document Health and Wellbeing 2026: Delivering Together sets out the commitment to develop, design and deliver healthcare that will enable sustained improvement.

Demand for health and social care in Northern Ireland (NI) has never been higher, and will only increase as our population is growing and ageing. Thanks to healthier lifestyles, and advances in medical science and technology, people are living longer. However, these improvements also mean that, in many cases, people are living with more than one health condition that is often becoming more complex. The system as currently structured, cannot keep pace with this growth in demand, and is thus unsustainable in its current form. There is no option but to transform how we deliver health and social care.

Our staff will of course be central to the transformation agenda. The development of a Health and Social Care (HSC) Workforce Strategy, focusing on the recruitment, retention, and ongoing development of all staff, including undergraduate and master's training, is a key component for successful transformation.

The collective expertise of Allied Health Professions (AHPs) within the workforce makes a significant contribution to improving the health and well-being of the population of NI. AHPs have a crucial role to play in driving innovation, helping to develop creative solutions to current and future health challenges.

I am delighted that in support of the HSC Workforce Strategy Policy, the DoH AHP Lead Officer along with professional colleagues have developed an Advanced AHP Practice Framework to underpin this work.

The move to a standardised use of titles, bands and competencies across the diverse range of AHPs will provide clarity for the public, service users, partner agencies and HSC colleagues.

I am pleased to endorse this framework and the recommendations to ensure that AHP skills are fully utilised to release greater capacity in certain specialty practice areas.

Richard Pengelly

Foreword by the DoH AHP Lead Officer

The need for transformation of services across health and social care in NI has been clearly articulated in the recent Bengoa Report, Systems Not Structures, and current policy document, Health and Wellbeing 2026: Delivering Together. The DoH response to the Bengoa Report stresses the need to deliver person-centred care, focused on prevention, early intervention, supporting independence and well-being, and delivered in the most appropriate setting in people's communities and at home. AHPs locally and nationally are extending their roles and skills in response to new strategic directions.

This NI Advanced AHP Practice Framework has been developed to provide clarity about the Advanced AHP Practitioner role and to underpin the DoH AHP workforce reviews. It provides a regional approach to addressing the needs of advanced AHP practice within the HSC in NI for application by Trusts, commissioners, education providers, workforce planners and Advanced Practitioners.

The framework outlines the knowledge, skills and competency level for each of the Advanced Practitioner roles within the 13 AHP disciplines.

It defines what advanced practice is, and clarifies formal educational pathways and clinical practice progression. Progress from newly qualified to expert is a developmental pathway and includes advanced practice. Nationally, Advanced Practitioner practice for AHP starts at Band 7 level and extends onwards to 8a and Consultant roles. The framework adopts the national directive and uses the two levels for Advanced Practitioners as are in Wales, England and Scotland.

The framework is solely applicable to AHPs, and is not a tool to challenge grading of current posts. Its key purpose is to inform knowledge, skills and competencies required for advanced practice roles within HSC AHP services.

Hazel Winning

Acknowledgements

I would like to acknowledge the excellent work of Paul Rafferty, Head of AHP Services, Western HSC Trust who led the working and the writing group facilitated by Maxine Williamson, Principal Consultant, HSC Leadership Centre for the commitment and dedication to undertaking this work supported by the Steering Board initially chaired in late 2016 by Carmel Harney, Assistant Director Southern HSC Trust.

I would also like to recognise the valuable contribution and dedication of those AHP staff and service users who contributed to the framework and consequently, the development of this document. The timely publication of this framework will help inform the roles and education and training needs for AHPs across NI.

Definition of Allied Health Professionals

The Allied Health Professional (AHP) workforce in Northern Ireland (NI) consists of 13 distinct and unique disciplines. These are: Dietitians, Occupational Therapists, Orthoptists, Paramedics, Physiotherapists, Podiatrists, Speech and Language Therapists, Radiographers, Art Therapists, Drama Therapists, Music Therapists, Orthotists and Prosthetists.

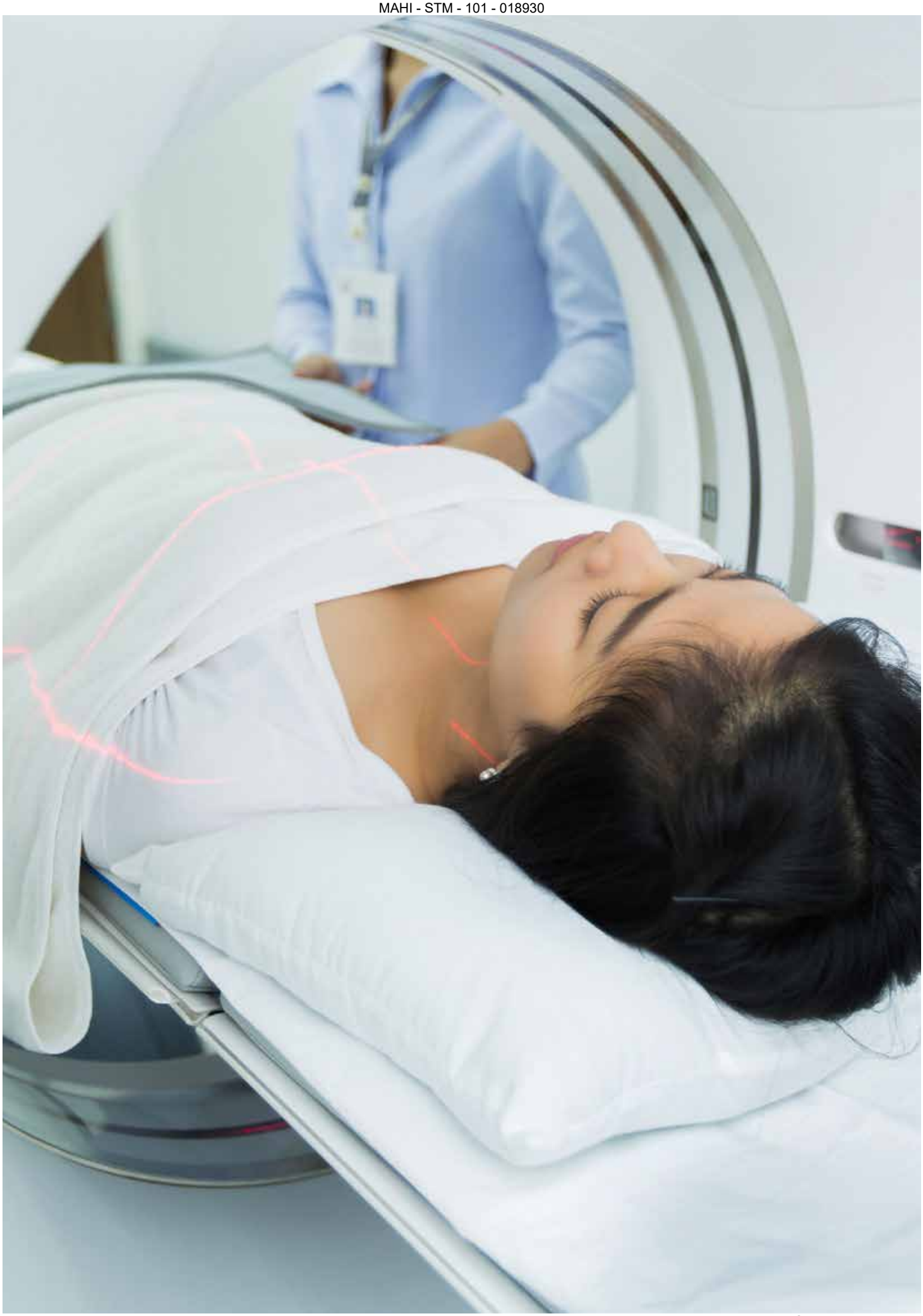
AHPs play a key role and add critical value across the full range of primary and secondary prevention, assessment, diagnosing, treatment and care. Working as integral parts of multidisciplinary teams and focusing on people's personal outcomes, they provide preventative interventions in areas such as self-management, diagnostic, therapeutic, rehabilitation and enablement services.

Current Clinical Career Progression

After completing undergraduate training AHPs enter the work environment at Band 5 level. It is anticipated that AHPs, having acquired the agreed level of experience and competency, will move in line with national job profiles into Band 6 level posts (i.e. Specialist), before progressing into Advanced Practitioner roles. All 13 AHP titles are protected and regulated through the Health and Care Professions Council (HCPC). This framework focuses on Advanced Clinical Practitioners (ACP) (Level 1 and Level 2), which are at Band 7 and Band 8a (see Figure 1 below). No posts below Band 7 (Level 1) should be permitted to use 'advanced practice' in their title since the post would not meet the level of knowledge, training and experience to be able to undertake this role.

Figure 1 – Clinical career progression

Note: As part of the assurance framework for professional accountability for HSC employed staff there will be a designated Head of Service in every Trust (DHSSPS, 2012).



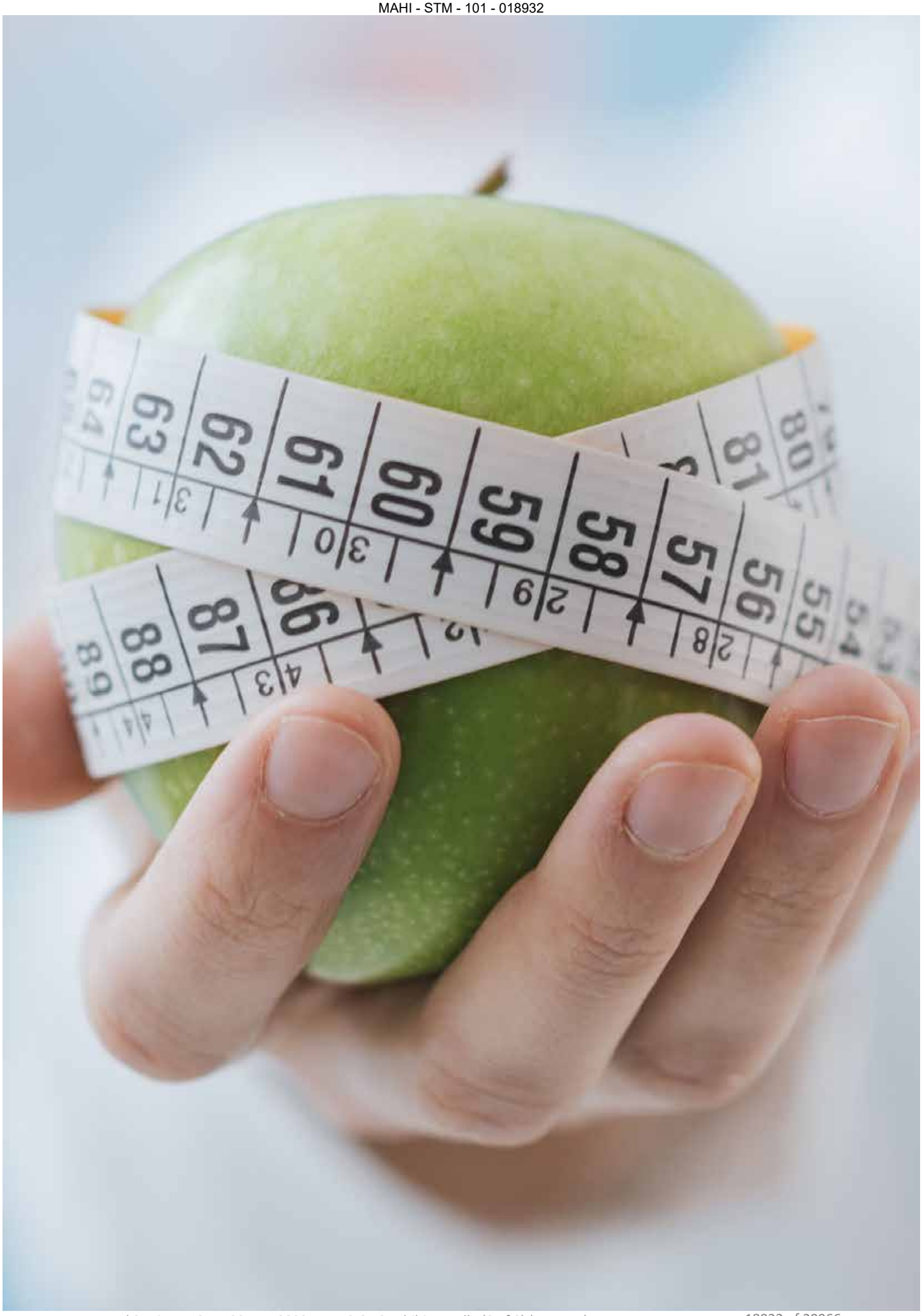
Development of this Framework

The concept of advanced AHP practice is not new as clinicians continue to develop clinical expertise, advancing and extending their scope of practice to maximum effect.

The lack of clarity or universal understanding regarding the precise nature of an Advanced Practitioner role within the AHPs leads to misunderstanding between specialist and advanced practice. This framework will provide clarity for the public, service users, clinicians, partner agencies and HSC colleagues. Moving to a standardised use of titles, bands and competencies across the diverse range of AHP disciplines will provide a more informed, consistent understanding of the roles and skills of AHPs.

This framework was co-produced and designed with AHPs across all disciplines, with input from service users. A stakeholder event was held which captured feedback and key themes; these included the definition of advanced practice, role and application of core competencies, career pathways and postgraduate education and training programmes. Any changes to agreed job titles and essential criteria will start with the launch of the framework. This will mean the guidance outlined in the framework will be applied 'going forward' and should have no regrading implications. The key purpose of agreed 'working titles' is to have less confusion in the system particularly for service users. The titles suggested are an umbrella term, which would cover the job profiles and will not affect Agenda for Change (AfC) (NHS Employers, 2018/2019).

This framework seeks not to limit organisations in the development of specific posts, but to provide a benchmark for this important level of practice.



Purpose of the Advanced AHP Practice Framework

NI's Advanced AHP Practice Framework has been developed to provide clarity about the Advanced AHP Practitioner role. It provides a regional approach to addressing the needs of advanced AHP practice within the HSC in NI for application by Trusts, commissioners, education providers, workforce planners and Advanced Practitioners.

The framework outlines the knowledge, skills and competency level for each of the Advanced Practitioner roles within the 13 AHP disciplines. It will:

- provide support to all regional organisations in the recruitment and development of AHPs;
- improve consistency across the HSC in the recruitment and development of AHPs and support advanced AHP practice;
- assure organisations that AHPs are aligned with the right skills in the right place at the right time to maximise health and well-being outcomes for patients, clients, service users and carers:
- provide AHPs across all disciplines with clearly defined career pathways and development opportunities;
- support and inform the ongoing or future regional workforce review.

The Advanced AHP Practitioner is a clinically focused role. As it is continually evolving, the elements contained within this framework will require periodic review.

What is Specialist Practice?

A Specialist has developed skills in an area that requires further education, training and practice beyond that of a newly qualified AHP. It is usually undertaken at Band 6 level and is often supported by a recognised postgraduate level qualification, where one is available, and is on the development continuum from 'novice' to 'expert'.

This should be differentiated from AHPs working in a specialist area, which is particular to a specific clinical context, be it a client group, a skill set or an organisational context. AHPs can work in a specialist area at all levels, from newly qualified registrant under supervision to Consultant level.

5

What is Advanced AHP Practice?

Advanced AHP practice is not new. For some time clinicians have been developing clinical expertise, advancing and extending scope of practice, often working beyond the boundaries of professional training. In recent years the designation of an 'advanced practice' title within the AHP disciplines has become more developed. This has been brought about through the establishment of new and extended roles to ensure that AHP skills are fully exploited and to release greater capacity for some specialty practice areas within the medical profession, facilitating doctors to focus on even more complex case work.

There is, however, a lack of clarity or universal understanding regarding the precise nature of an Advanced Practitioner role within the AHPs. There has also been a blurring between specialist and advanced practice. Defining what advanced practice is clarifies this and allows for formal educational and clinical practice progression. Advanced practice, it is argued, is a particular stage on a continuum between 'novice' and 'expert' practice. The 'advanced' role profile is characterised by high levels of clinical skill, competence and autonomous decision making. Progress from newly qualified to expert is a developmental pathway and includes advanced practice.

There are a number of definitions of an Advanced Practitioner as well as differing academic requirements. The following are definitions of advanced practice (sometimes also referred to as Advanced Clinical Practitioner (ACP) in England, Scotland and Wales):

'ACP is delivered by experienced registered healthcare practitioners. It is a level of practice characterised by a high level of autonomy and complex decision-making. This is underpinned by a Masters' level award or equivalent that encompasses the four pillars of clinical practice, management and leadership, education and research, with demonstration of core and area specific clinical competence.

ACP embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes.' (NHS Health Education England)
'A role, requiring a registered practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competencies for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant Masters level education is recommended for entry level.' (National Leadership and Innovation Agency for Health Care, 2010)

'Experienced clinical practitioners with a high level of skill and theoretical knowledge. Will make high level clinical decisions and manage their own workload.' (NHS Education for Scotland, 2012)

A master's level qualification would be desirable, if available, for the AHPs in NI. However, the diverse and complex skills required of Advanced Practitioners in the 13 disciplines make a universal master's qualification impossible to deliver. A master's level qualification or equivalent could therefore include a number of postgraduate short courses, focused mentorship over a prolonged period and/or extensive experience in an area of advanced practice.

An agreed definition of Advanced Practitioner for NI is as follows:
'A role, requiring a registered experienced practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competences for expanded/extended scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant education is recommended for entry level to the advanced practice role which is to be at master's level or equivalent and which meets the education, training and Continuous Professional Development (CPD) requirements for ACP as identified within the framework.' (Adapted from National Leadership and Innovation Agency for Healthcare, 2010 and NHS England, 2015)

6

Due to the diverse nature of AHP working, profession-specific requirements will be detailed in individual job specifications. Reference to 'master's level' in the definition consists of master's level (or equivalent) education which may include individual modules or a complete master's degree.

An agreed definition, therefore, of an Advanced Practitioner role is one which is characterised by a high level of autonomy and complex decision making underpinned by master's level education (or equivalent) that encompasses the four pillars of advanced clinical practice; leadership and management; education of self and others; and research.

In Northern Ireland AHP Advanced prctitioners now have the opportunity to complete an AHP Post Graduate Certificate in Education (PGCE) course to develop a more educational role specific to their clinical speciality.

This will create a network of identified clinicians who are competent to deliver education and training within their clinical specialities.

Relationship between Specialist and Advanced Practitioner

In order to promote and support advanced practice within an AHP framework, it is useful to define what is typically the difference between a Specialist and Advanced Practitioner. A number of differences have been identified and although most of these are generic, there will be some very specific differences identified within each profession. Practitioners within each of the professions will be able to identify some which are applicable to their area of work. Table 1 lists some examples.

Table 1 – Differences Between Specialists and Advanced Practitioners

SPECIALIST	ADVANCED PRACTITIONER
Typically works at Band 6 level.	Typically works at Band 7 and above.
Will have additional qualifications or experience over and above that expected of a Band 5 practitioner.	Will have significant clinical expertise in a defined area of work (e.g. imaging modality, system, disease, treatment etc.) and is regarded by his/her peers as an expert in this field.
Will have ready access to a more senior practitioner for advice.	Would be expected, as the expert in the field, to be available to other less experienced staff and peers to offer support and advice in relation to their specialist area of advanced practice.
Would follow agreed procedures and protocols and make suggestions or amendments to them.	Would be responsible for drafting and oversight of the implementation of specialist work practices in their area of expertise.

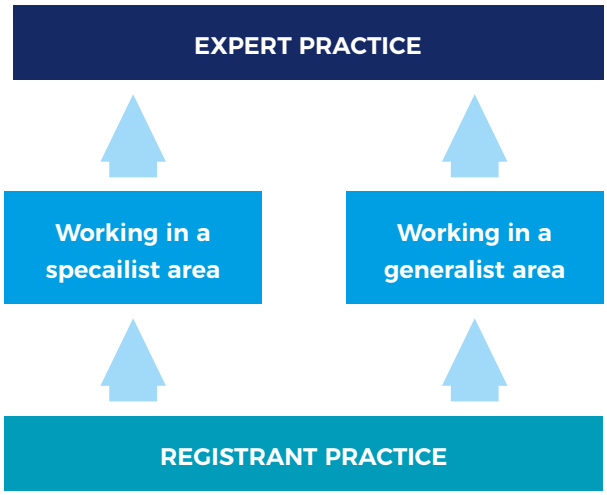
7

SPECIALIST	ADVANCED PRACTITIONER
May have postgraduate level qualification, e.g. postgraduate modules, a postgraduate certificate or diploma or have attended a number of short courses aimed at a well-defined area of specialist work. It is acknowledged that not all professions have ready access to postgraduate level qualifications.	Would be expected to have completed a relevant master's level (or equivalent) education qualification, e.g. postgraduate modules, a postgraduate certificate or diploma or MSc. They are likely to have attended a number of short courses aimed at a well-defined area of specialist work and have developed significant expertise (clinical, managerial or in an education arena) which will allow them to define and introduce new practices and ways of working.

Advanced practice is a point on a continuum between 'registrant' and 'expert' practice. The Advanced Practitioner role profile is defined by high levels of clinical skill, competence and autonomous decision making.

Both Specialist and Advanced Practitioner roles are on the development (vertical) continuum from registrant to expert practice (Figure 1). The developmental pathway towards advanced practice is varied with some following a specialist clinical route, (focusing on a particular client group or clinical context), whilst others will develop a portfolio with a breadth of practice (Figure 2).

Figure 2 – Relationship between working in specialist/generalist clinical areas and advanced practice



The light blue arrows in Figure 2 illustrate that individual practitioners can progress to expert practice anywhere along the specialist or generalist areas of clinical work providing they develop and meet the required core competencies as described in Appendix 1.

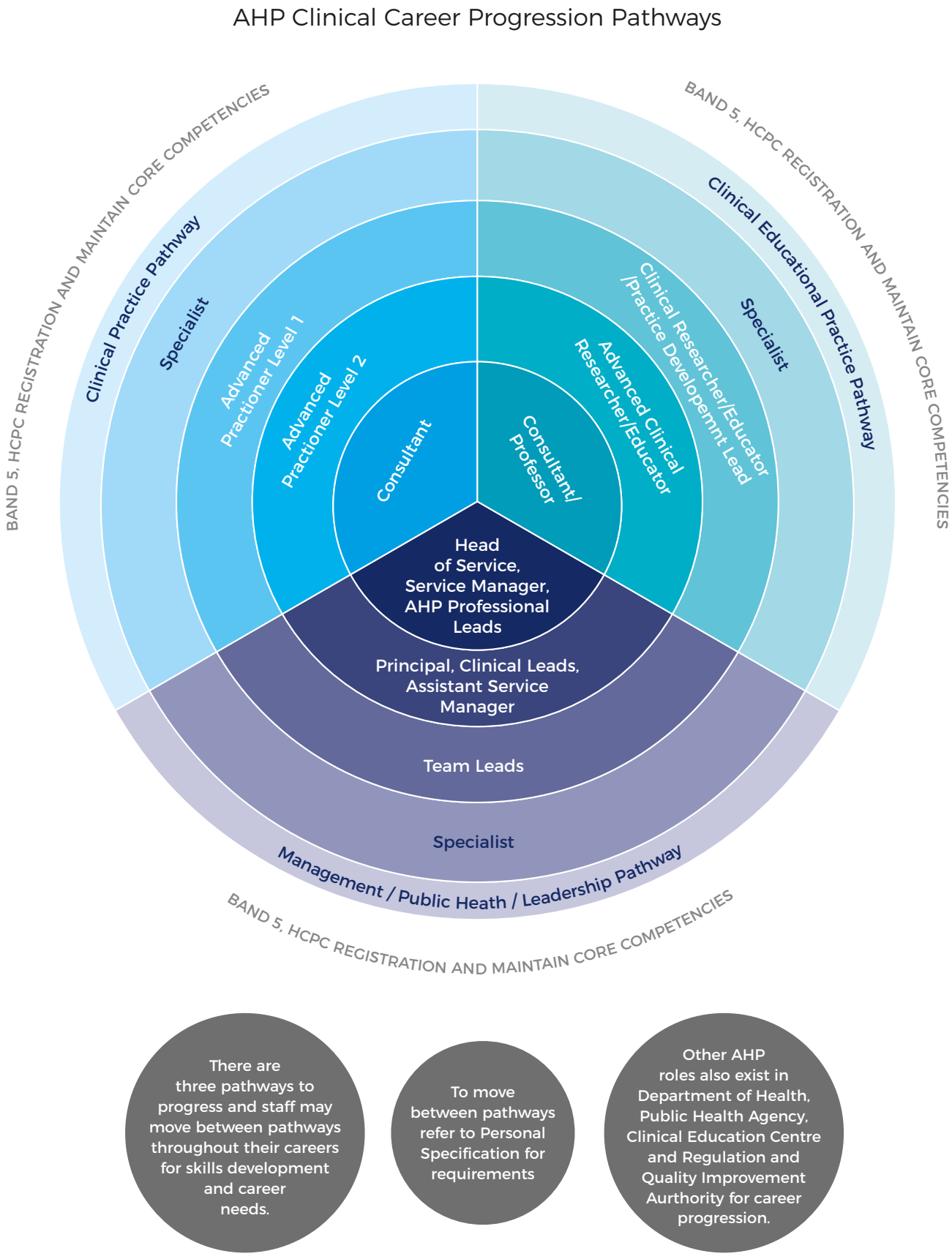
By defining specialist and advanced practice and the relationship with working in specialist or generalist clinical areas, we can then define career progression as an expert practitioner in figures 1 and 3. Nationally, Advanced Practitioner practice for AHPs starts at Band 7 level and extends onwards to Band 8a and Consultant roles (Figure 1). The Advanced Practitioner roles at Level 1 and Level 2 adopted are recognised nationally in Wales, England and Scotland. Level 1 sits at Band 7 and Level 2 at Band 8a on the AfC pay scales (section 4.0). Guidance on core competencies and core learning outcomes for Advanced AHP Practitioner Level 1, Advanced AHP Practitioner Level 2 and Consultant roles is given in Appendix 1.

Figure 3 (AHP clinical career progression pathways) describes potential career development pathways for all AHPs. There is an acknowledgement that AHPs may move between the various pathways at different points during their professional career and this practice is to be encouraged. For clarity, however, the shifts between the three pathways have not been included in the diagram.

Managerial accountability for individual staff rests with the various employers who are separate legal entities, i.e. AHPs may be employed by HSC Trusts, Public Health Agency (PHA), Health and Social Care Board (HSCB), universities, Clinical Education Centre (CEC), The Regulation and Quality Improvement Authority (RQIA) or others. The managerial and governance arrangements are described in local documents.

7

Figure 3 - AHP clinical career progression pathways



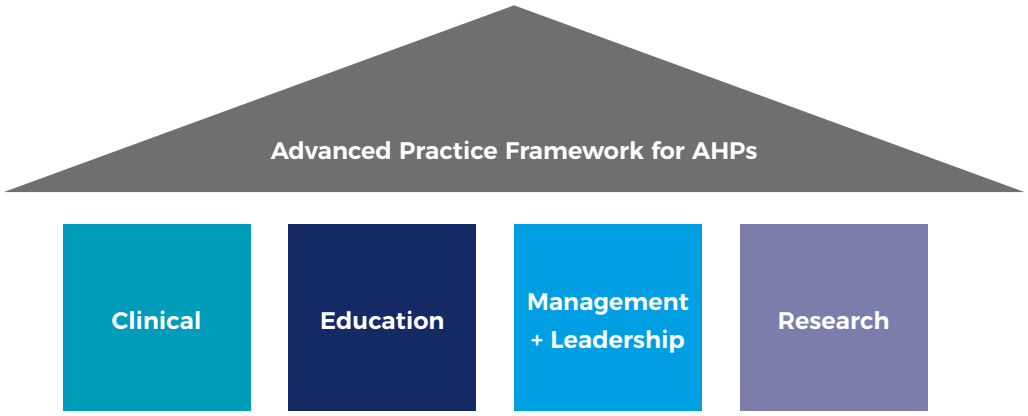
7

Core Competencies for Advanced AHP Practice

NI, in line with the other UK countries, England, Scotland and Wales, recognises that clinicians identified as Advanced Practitioners should be expected to work, practice and function to the same standard and will be supported and empowered by their organisations to make high level decisions of similar complexity and responsibility.

Within this framework, a core principle is for advanced practice to be defined as a level of practice rather than a specific role. The required level of practice is characterised by functions set out within the clinical, research, education and managerial/leadership domains. These functions are articulated as pillars of advanced practice (Figure 4). These will define the competencies for advanced AHP practice. These pillars were developed from National Executive Scotland (2007; see Appendix 2).

Figure 4 – Core competencies for advanced AHP practice



8

Whilst the specific composition of individual roles will be determined locally, every advanced practice post will require evidence of skills in each of the four key functions (pillars) in order to be deemed competent. The split between the functions will be determined by the requirements of the post, e.g. a teaching post will have a higher proportion of education skills required.

Other opportunities for advanced practice roles can be offered by other agencies/bodies e.g. posts may be available in the PHA in both specialist projects and strategic development or AHP leadership and policy at the DoH, or in the Housing Executive.

APPLICATION OF CORE COMPETENCIES

The four core competencies relevant to the Advanced AHP Practitioner's role have specific core learning outcomes and are presented in Appendix 3.

The learning outcomes have been developed to guide:
curriculum development of the MSc level educational and training programmes (commissioned by the DoH);
development of job descriptions for Advanced AHP Practitioners;
ongoing learning and development of the individual employed in the role.

The core competencies and core learning outcomes will complement other generic competency frameworks which are relevant to the Advanced AHP Practitioner's role, such as Knowledge and Skills Framework (DH, 2004); Healthcare Leadership Model (NHS Leadership Academy, 2013); Attributes Framework (DHSSPS, 2014).

8

The Advanced AHP Practitioner Role

There are many instances in which AHPs have been pivotal to service redesign and the achievement of performance targets. This is particularly evident where Advanced AHP Practitioners have become integral to the development of sustainable and affordable multidisciplinary teams. AHPs also play an integral role in the public health workforce in designing and delivering improvements to health and well-being and reducing health inequalities. The Advanced Practitioner promotes and protects health and well-being, prevents ill health and prolongs life using their unique skills, knowledge and experience to deliver public health improvement. They also play a key role in the education of others, including those in multidisciplinary teams. Appendix 4 gives examples of AHPs working in advanced practice roles.

The Advanced AHP Practitioner:

- practices autonomously, whilst being accountable and self-directed in line with the relevant code of professional conduct;
- provides highly specialised, high quality, person-centred care which always considers people's safety, privacy and dignity using advanced clinical knowledge that is evidence based;
- plans and manages complete episodes of care; undertakes independent comprehensive assessment and management of service users to incorporate, for example, pharmacological considerations; makes complex clinical decisions regarding service user management and clinical outcomes;
- leads as a driver for change, to monitor and improve standards through supervision, evidence-based practice, clinical audit, research and education;
- contributes to and undertakes activities, including research, that monitor and improve the quality of healthcare and the effectiveness of practice;
- provides expert clinical advice, leadership and support ensuring the needs of the service are met by exercising and demonstrating high levels of clinical judgment, critical analysis and advanced decision-making skills, promoting and demonstrating best practice by integrating evidence into practice;

- works strategically contributing to the planning and development of integrated services;

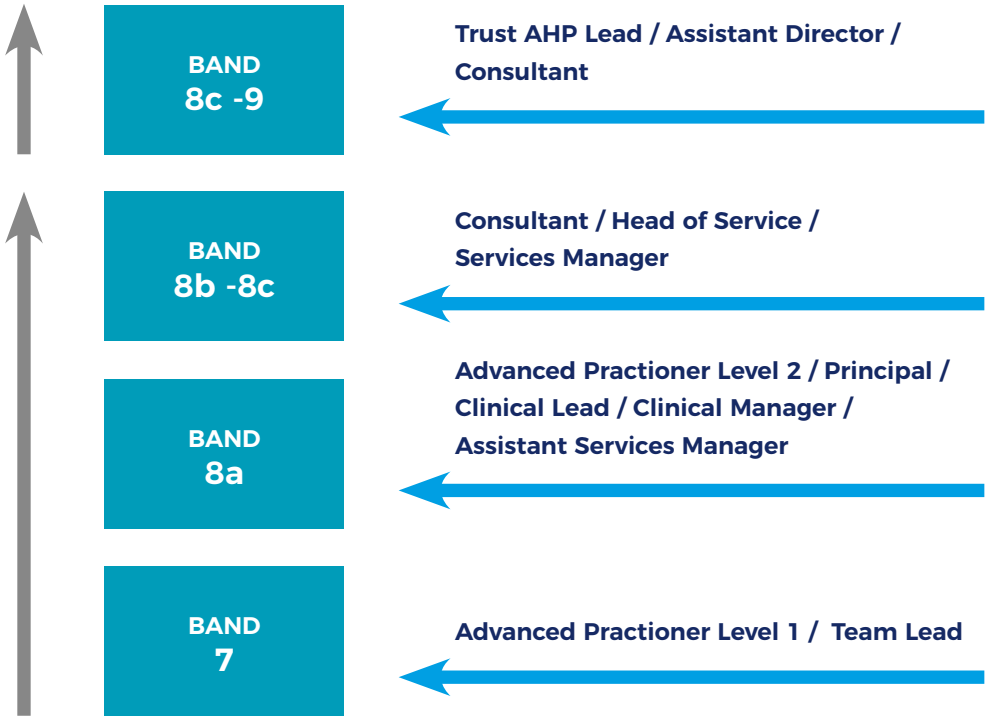
- is accountable for the direct delivery of autonomous service user care.

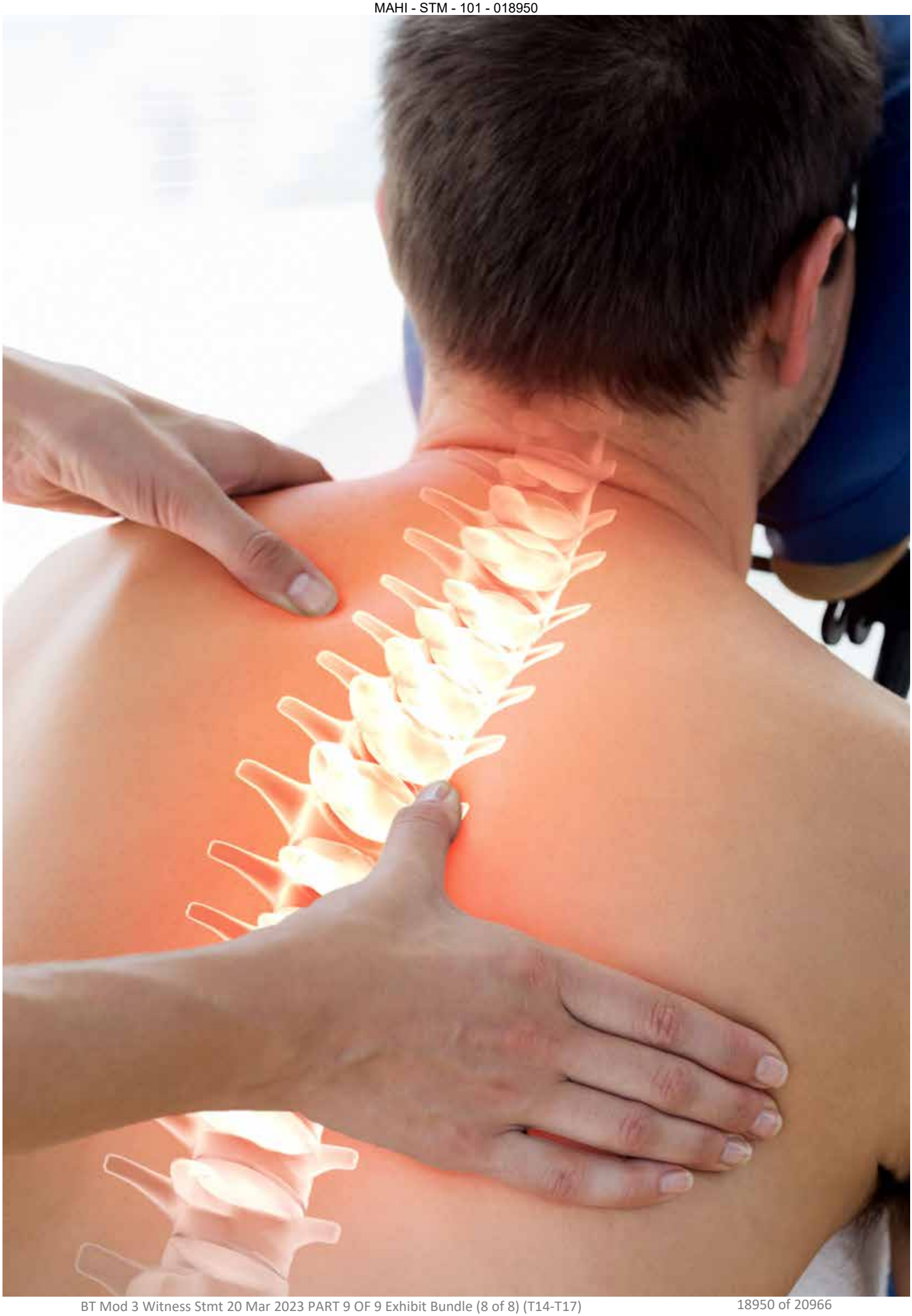
(Source: Extracts from Dorset Healthcare University – NHS Foundation Trust)

Going forward in recruitment it must be noted that only those who meet the requirements of the role and who are employed as Advanced AHP Practitioners, will be able to use the title.

The regional scoping exercise undertaken as part of the development of the framework highlighted a great deal of inconsistency in the grading and titles of extended scope practice that this document defines as advanced practice (Appendix 3). Following extensive discussions within both the steering and working groups (Appendices 5 and 6), which is representative of managers, staff side and education providers, it is recognised that a clear framework underpinned by the principles within AfC is important to reflect the requirements for development of these posts. Whilst it is recognised that clinical competencies are not directly correlated to pay bands, Figure 5 provides some guidance (but should not be applied rigidly) in mapping to job roles. The Advanced Practitioner roles at levels 1 and 2 are recognised nationally.

Figure 5 – Guidance on job roles and pay bands





Academic and Clinical Preparation for Advanced AHP Practitioners

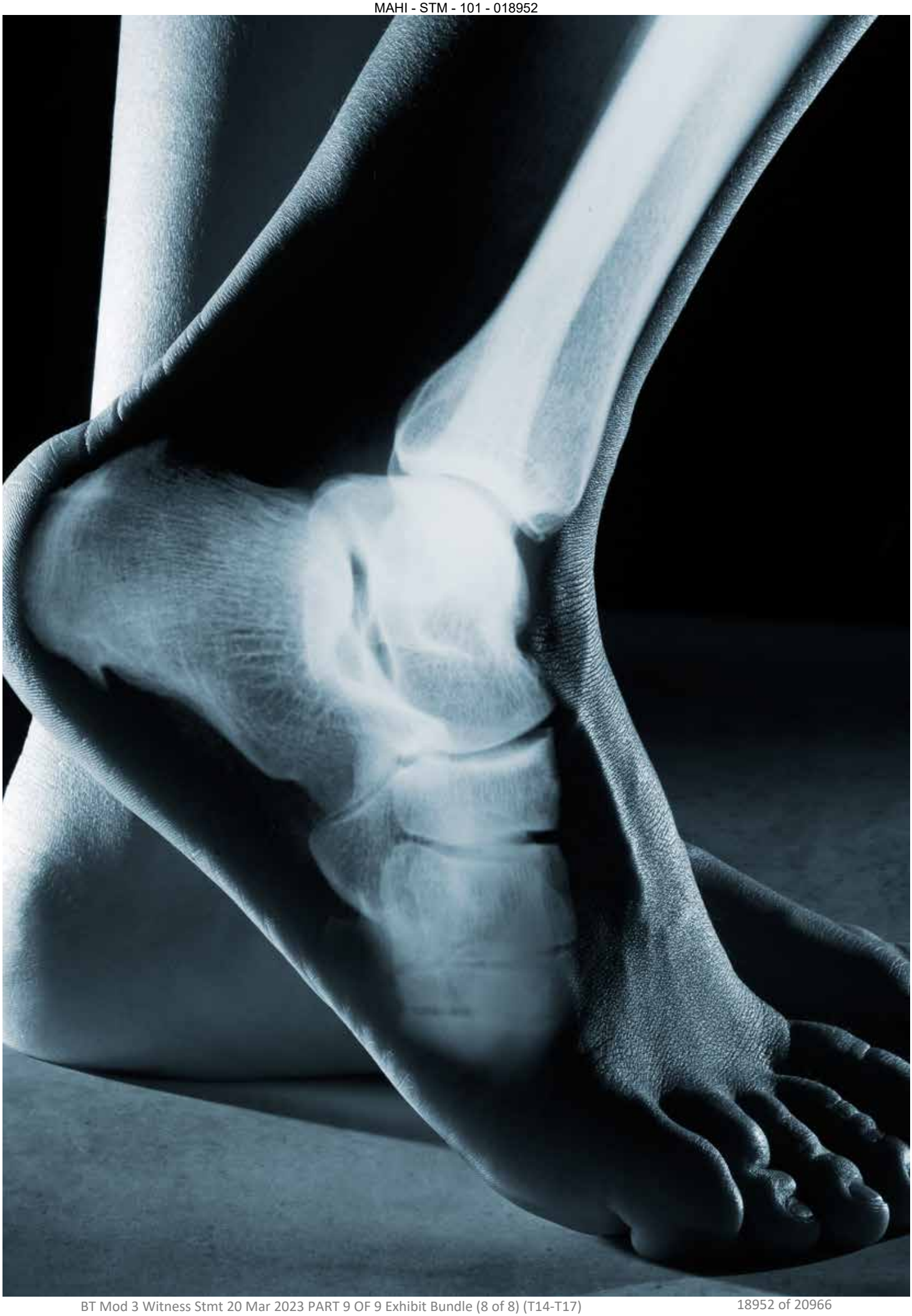
In addition to experiential learning, progressing to the Advanced AHP Practitioner role requires significant educational support to enable provision of enhanced service user care.

Educational provision combined with experience and practice, supports the development and recognition of advanced practice capability in a practitioner. This process prepares a practitioner with the ability to fulfil the requirements and expectations of such a level of practice, but does not in itself grant the practitioner an Advanced Practitioner status.

It is essential that AHP clinical leaders and education providers develop education that is relevant to clinical practice and service user needs. Higher education institutions and in-service education will need to respond flexibly to changing requirements and service transformation. This will require high levels of partnership and collaborative working between HSC organisations and education providers.

Advanced Practitioners will be supported in their job role as outlined in the AHP support and supervision policy and underpinned by the governance principles as outlined in the current AHP strategy (DHSSPS, 2012) and any future AHP strategies.

10



Advanced AHP Practice Postgraduate Education and Training Programmes

In order to effectively deliver an Advanced AHP Practice Framework, robust and ongoing commitment to postgraduate education and funding is essential. Postgraduate modules/certificate/diploma/MSc in advancing practice offer AHPs the opportunity to engage in CPD. As the role of Advanced Practitioner develops, future programmes should be designed with both uni-professional and inter-professional modules to allow AHPs to move through career pathways. Some modules may only be applicable to one profession and will have been developed accordingly. Interdisciplinary working should be encouraged so that modules are shared across programmes where educationally appropriate. Some of the inter-professional modules may include a number of professions; however, depending on the provider there may be compulsory modules and modules which are suitable for all the AHPs . This will enhance an understanding of the contribution other professions make to the service user's journey.

In line with the previous definition of master's level qualification, and taking into account 'equivalency', providers in the future must evidence that they can provide sustainable modules which use a flexible but clear module structure that enables practitioners to engage with a single module (short course) or to work towards an award of PgCert/Dip/MSc advancing practice in (AHP specialism). These programmes must be able to demonstrate academic and practical aspects using learning methods which allow for reflection on current theory, the available evidence base, current practice and practical translations into enhancement of practice. Modules will have been developed in partnership with clinical colleagues and professional experts.

As a result, graduates from these programmes will demonstrate a high level of critical thinking and cognitive skill in respect of analysis, synthesis and objective evaluation of complex issues. This will enable them to demonstrate creativity in identifying and solving situations and problems, with the outcome of advancing their practice. The key skills developed would transfer to other situations and work environments. The skills developed will allow Advanced Practitioners to focus on solution finding, leadership, organisation of time and task, ability to use and conduct research and effective use of information technology. They will have enhanced interpersonal qualities, most notably in respect of leadership roles, critical reflection on one's own practice and being an agent of change in their work environment, and develop expert practice in their field.

11

Core Competencies and Core Learning Outcomes

Guidance in relation to core competencies required for staff are attached in Appendix 3. This shows what clinical, leadership, education and research competencies staff must attain in order to move through their career pathway. This will help staff through their supervision and appraisal process to develop their knowledge and skills in order to apply for advanced practice posts.

12


BULANCE
LANCE

Application of the Advanced AHP Practice Framework

The implementation of this framework will ensure a more consistent approach across NI to the development and management of future Advanced Practitioner roles. It will ensure a consistent approach is taken to the use of job titles and that appropriate governance arrangements are in place to support advanced level practice. Changes to agreed job titles and essential criteria will start at a point in time – this would apply in a 'going forward' approach and should have no regrading implications. The key purpose of an agreed 'working title' is to have less confusion in the system and with service users. The titles suggested would be an umbrella term which would cover the job profiles and will be linked to the national matching profiles, therefore not affecting AfC processes/outcomes. Once finalised, the framework will be issued by DoH Workforce Planning Directorate to all Chief Executives of HSC Trusts to implement. Trusts will be directed to comply with the titles, bandings and competencies set out in the framework.
It is recognised that there are funding and resource implications in developing Advanced Practitioners, and this will be addressed via the Regional AHP Education Commissioning Group and Trust Managers, who will also consider the findings from the AHP workforce reviews. It is also envisaged that a framework document of AHP associates will be developed in the future, to enable current local HSC AHP Advanced Practitioners with clinical expertise, to contribute to education and training provision. This work will be taken forward through the AHP Lead Officer at the DoH.

Appendix 1

CORE COMPETENCIES AND CORE LEARNING OUTCOMES – GUIDANCE

All job descriptions must be based on AfC national profiles. This is not an exhaustive list of competencies at each level and should be used for guidance. It is recognised that some competencies may overlap across some of the levels. To progress from Level 1 to Level 2 it is expected that staff will evidence the competencies at Level 2. When staff are promoted to Level 2 they will be expected to ensure they have met the competencies at Level 1. Each AHP Head of Service is responsible for ensuring the competencies of each post match their service model requirements.

CORE COMPETENCY 1 – DIRECT CLINICAL PRACTICE

The Advanced AHP Practitioner Level 1 will:

1	Practice autonomously, providing high quality innovative clinical practice
2	Be proactive in clinical decision making underpinned by an advanced level of theoretical and practical knowledge
3	Undertake comprehensive specialist holistic assessment of, or perform diagnostic tests or interventions on service users, in collaboration with their carers where needs are highly complex
4	Use advanced clinical skills in assessment, diagnoses, treatment and discharge of service users
5	Demonstrate a high level of knowledge in relation to pattern of disease or disorder, markers of condition progression and range of treatment available at each stage of disorder or condition
6	Where appropriate to profession, act as an independent non-medical/supplementary prescriber, able to take a history, assess, examine, diagnose and prescribe, and develop a management plan including medication and monitor response to medication.

The Advanced AHP Practitioner Level 2 will:

1	Develop and implement the highest quality innovative clinical practice
2	Be proactive in clinical decision making underpinned by the highest level of theoretical and practical knowledge and be able to demonstrate improved service users outcomes
3	Undertake comprehensive specialist holistic assessment of service users and carers where needs are highly complex. This will involve planning, implementing and evaluating the care delivery according to changing healthcare needs
4	Work autonomously using advanced levels of history taking and examination skills within multidisciplinary team, guidelines and protocols
5	Use advanced clinical skills in assessment, diagnoses, treatment and discharge of service users
6	Demonstrate a high level of knowledge in relation to pattern of disease or disorder, markers of condition progression and range of treatment available at each stage of disorder or condition
7	Where appropriate to profession, act as an independent non-medical/supplementary prescriber, able to take a history, assess, examine, diagnose and prescribe, and develop a management plan including medication and monitor response to medication
8	Advise and communicate as appropriate with acute hospitals, primary and social care and community teams thus ensuring seamless continuity and transfer of care for service users between other relevant health, social and third sector agencies, professionals and other care settings
9	Establish, maintain and effectively manage barriers to advanced, highly skilled and effective communication with service users, carers and professionals across health and social care, in order to develop a therapeutic relationship within which highly sensitive, distressing health conditions and highly complex issues are often addressed. This includes imparting information regarding diagnosis, prognosis and treatment and referring to other teams as appropriate to promote integrated working and to improve service user outcomes.

The Consultant will:

1	Have a highly visible clinical profile, spending at least 50% of time in clinical practice, providing both advisory and clinical input into patient/client care
2	Develop and implement the highest quality innovative clinical practice. Be proactive in clinical decision making, underpinned by the highest level of theoretical and practical knowledge
3	Undertake comprehensive specialist holistic assessment of service users and carers where needs are highly complex. This will involve planning, implementing and evaluating the care delivery according to changing healthcare needs
4	Authorise the decision to admit service users and/or proactively initiate discharge
5	Work autonomously using advanced levels of history taking and examination skills within multidisciplinary team, guidelines and protocols
6	Utilise expert clinical skills in assessment and/or formulate a diagnosis and/or treatment plan.

CORE COMPETENCY 2 – LEADERSHIP AND MANAGEMENT

The Advanced AHP Practitioner Level 1 will:

1	Inspire and demonstrate leadership qualities through delivery of specialist advice, working with others, demonstration of personal qualities, continuous service improvement, and setting direction
2	Manage change through strategic thinking, use of negotiating skills, self-awareness and effective communication
3	Act as a role model, provide professional leadership to the team and promote the Trust/organisation behaviours of being proactive, positive, respectful, supportive, reliable and trustworthy.

The Advanced AHP Practitioner Level 2 will:

1	Undertake clinical supervision and systematic peer review of colleagues on an individual or group basis
2	Contribute to investigation of incidents and complaints when required; participate in identifying lessons learnt and the sharing of learning across the organisation.

The Consultant will:

1	Provide leadership by setting a clear direction on service planning and delivery, leading discussions regarding requirements of the service, ensuring an innovative and high quality service is delivered
2	Act as a national leader in own specific field, creating opportunities to represent the organisation and also ensuring the organisation is aware of national changes to healthcare
3	Provide highly specialist advice and support to other professionals in the multidisciplinary team.

CORE COMPETENCY 3 – RESEARCH AND DEVELOPMENT

The Advanced AHP Practitioner Level 1 will:

1	Regularly undertake audit and service evaluation to inform service improvement
2	When necessary support and facilitate colleagues in research, clinical audit and clinical trials in order to improve effectiveness and quality of patient care
3	Critically analyse research findings and their implications for practice
4	Disseminate evidence-based practice and audit findings through local and/or regional presentation to professional groups
5	Review recent publications and research to ensure practice is evidence based and up to date.

The Advanced AHP Practitioner Level 2 will:

1	Facilitate learning for service users and their carers in relation to their identified health needs
2	In collaboration with other senior staff, ensure that clinical practice is patient centred and research based in accordance with professional practice, guidelines and national and local benchmarks
3	Regularly undertake audit and service evaluation to inform service improvement using an evidence-based approach to draw on best practice. When necessary support and facilitate colleagues in research, clinical audit and clinical trials in order to improve effectiveness and quality of service users' care
4	Critically analyse research findings and their implications for practice
5	Disseminate evidence-based practice and audit findings through local and/or regional presentation to professional groups.

The Consultant will:

1	Provide an environment that encourages client-centred involvement, where clients are facilitated to ask for help, advice and education
2	In collaboration with other staff ensure that clinical practice is patient centred and research based in accordance with professional practice, guidelines and national and local benchmarks
3	Act as a research champion; regularly initiate and undertake audit and service evaluation to inform service improvement using an evidence-based approach to draw on best practice. When necessary support and facilitate colleagues in research and clinical audit in order to improve effectiveness and quality of patient care. Participate in surveys as required.
4	Critically analyse research findings and their implications for practice, advising on the impact on practice and implementation
5	Encourage critical appraisal of research findings amongst colleagues, teaching these skills where appropriate.

CORE COMPETENCY 4 – EDUCATION

The Advanced AHP Practitioner Level 1 will:

1	Maintain up-to-date skills and knowledge relevant to their profession and specialist area by engaging in a range of relevant learning and development activities
2	Educate and supervise AHP colleagues and others in the healthcare team
3	Take advantage of education and training opportunities in line with their Personal Development Plan
4	Undertake self-reflection in line with CPD principles
5	Advocate and contribute to continuous learning and development, evidence-based practice and succession planning
6	Lead and contribute to a range of audit and evaluation strategies which informs education and learning.

The Advanced AHP Practitioner Level 2 will:

1	Develop and maintain high level advanced skills and identify learning and development needs for both self and others
2	Educate and develop others in advanced practice by supporting and facilitating colleagues
3	Actively support multidisciplinary learning and education where possible to promote their specialty and advance practice
4	Identify gaps in learning and have a role in exploring evidence-based education programmes for both themselves and other staff
5	Assist in the design and or delivery of programmes as part of a partnership approach with education providers.

The Consultant will:

1	Actively share learning and expertise with members of their own profession and other members of the multidisciplinary teams on both a local and regional basis
2	Support educational institutions in provision of clinical teaching or training
3	Promote advance practice and other service improvements at regional and national level at various fora including national and international conferences, specialist interest groups, national professional bodies etc. when developing guidelines
4	Work collaboratively with various professional bodies ensuring the AHP Advance Practice programme in NI is seen as an exemplar of best practice.

Appendix 2

ADVANCED PRACTICE PILLARS (ADAPTED FROM NATIONAL EXECUTIVE SCOTLAND (2007))

In 2007, National Executive Scotland developed the four advanced practice pillars and defined the characteristics of each. These have been adapted for the HSCNI in Table 1 below.

Table 1 – Advanced Practice Pillars

1. MANAGEMENT AND LEADERSHIP

- Identifying need for change, leading innovation and managing change, including service development
- Developing case for change
- Negotiation and influencing skills
- Networking
- Team development

2. EDUCATION (WITHIN EITHER CLINICAL PRACTICE OR EDUCATION SECTOR)

- Principles of teaching and learning
- Supporting others to develop knowledge and skills
- Promotion of learning/creation of learning environment
- Service user/carer teaching and information giving
- Developing service user/carer education materials
- Teaching, mentorship and coaching

3. RESEARCH

- Ability to access research/use information systems
- Critical appraisal/evaluation skills
- Involvement in research
- Involvement in audit and service evaluation
- Ability to implement research findings into practice, including use of and development of policies/protocols and guidelines
- Conference presentations
- Publications

4. ADVANCED CLINICAL PRACTICE

- Decision making/clinical judgment and problem solving
- Critical thinking and analytical skills incorporating critical reflection
- Managing complexity
- Clinical governance
- Equality and diversity
- Ethical decision making
- Assessment, diagnosis referral, discharge
- Developing higher levels of autonomy
- Assessing and managing risk
- Non-medical prescribing in line with registration
- Developing confidence
- Developing therapeutic interventions to improve service user outcomes
- Higher level communication skills
- Service user focus/public involvement
- Promoting and influencing others to incorporate values based care into practice
- Development of advanced psycho-motor skills

These pillars are further supported by the underpinning principles set out in Table 2, which demonstrate how the role fulfils the requirements of advanced practice.

Table 2 – Underpinning Principles of Advanced Practice

AUTONOMOUS PRACTICE
Advanced Practitioners practise autonomously, have the freedom to exercise judgment about actions, in turn accepting responsibility and being held to account for them.

CRITICAL THINKING
Practising autonomously requires 'self-regulatory judgment that results in demonstrating the ability to interpret, analyse, evaluate and infer' (Mantzoukas et al, 2007; 33). Critical thinking allows Advanced Practitioners to explore and analyse evidence, cases and situations in clinical practice, enabling a high level of judgment and decision making.

HIGH LEVELS OF DECISION MAKING AND PROBLEM SOLVING
It would be expected that an Advanced Practitioner can demonstrate expertise in complex decision making in relation to their current role. This includes determining what to include in the decision-making process, and making a decision based on judgment and critical thinking/problem solving. This is turn affects the ability to practise autonomously.

VALUES BASED CARE
At this level of practice, individuals are required to have a high level of awareness of their own values and beliefs. Care is negotiated with service user/carers as an equal partner. 'Working in a positive and constructive way with difference and diversity. Putting the values, views and understanding of individual service users and carers at the centre of everything we do'.

IMPROVING PRACTICE
It is important that Advanced Practitioners deliver advanced practice which is evidence based within service, whilst acting as a positive role model that enables change regardless of their job title.

Appendix 3

SUMMARY OF SCOPING EXERCISE

It was agreed as part of the development of the framework to conduct a scoping exercise across NI to capture the various job titles, experience required, qualifications/competencies and all essential criteria that exist across all AHPs from Bands 6 to 8b. An online questionnaire was drafted to capture this data by profession. This was issued to members of the Working Group to circulate to their regional colleagues for completion.

All responses were captured and following a review of the information collated from the scoping exercise the Advanced AHP Practice Framework Working Group made initial proposals for consideration by the Steering Board and respective profession regional colleagues across all Trusts.

ADVANCED PRACTICE

It should be noted that advanced practice is a level of practice rather than a role and is not exclusively characterised by the clinical domain, but includes working in research, education or managerial/leadership roles (recognised as pillars of practice). All advanced practice posts will contain some elements of each pillar. These are outlined in the framework.

Band	Current range of working titles in AHPs	Agreed working title/s going forward
7	Clinical Facing Clinical Specialist Clinical Lead Specialist Regional Clinical Specialist Specialist High Risk Specialist Advanced Clinical Specialist Advanced Practitioner Managerial or Managerial/Clinical Facing Team Lead Team Coordinator	AHP Advanced Practitioner Level 1 Team / Professional Lead
8a	Clinical Facing Lead Clinical Clinical Specialist Principal Principal Clinician Extended Scope Practitioner Regional Clinical Specialist Service Lead Assistant Manager Consultant Managerial or Managerial/Clinical Facing Deputy Manager	AHP Advanced Practitioner Level 2 Principal Clinical Lead / Manager Assistant Services Manager
8b–8c	Clinical Facing Consultant Managerial or Managerial/Clinical Facing Head of Service AHP Lead AHP Lead for designated operational services within a specialty area, for e.g. disability, children and young peopleTrust-wide Lead Professional, i.e., for Dietetics, Radiography Trust-wide Prof HOS, i.e., Physiotherapy, Occupational Therapy, Podiatry	Consultant Head of Service Services Manager

	Level of competency	Outputs – what the job will deliver
	Minimum 3 years' postgraduate experience at Band 6 relevant to the post Master's education / modules (or equivalent) or willingness to complete education and training within 12–18 months	Highly developed specialist knowledge underpinned by theory and experience Making high level clinical decisions dealing with complex facts and situations requiring analysis and interpretation Provides day-to-day management of a team of staff – manages and develops staff including participation in recruitment, appraisal, and performance
	Minimum 2 years at Band 7 level relevant to the post OR, in exceptional circumstances where appropriate, 7 years' postgraduate experience to include minimum of 5 years at a specialist grade or above in the specialist field Master's education / modules (or equivalent) or a requirement to complete education and training within 12–18 months	Working at a high level of clinical expertise and/or have responsibility for planning services Lead on implementation of professional clinical governance frameworks and support others in its use
	Dependent on post requirements, responsibility and accountability	Practise autonomously guided by expert understanding of policies, procedures and guidelines Anticipate and predict risks/benefits through application and analysis of data, evidence and strategic awareness Staff working at a very high level of clinical expertise and/or have responsibility for planning services

Band	Current range of working titles in AHPs	Agreed working title/s going forward	
8c +	Managerial/Strategic The Nominated Trust AHP Lead Assistant Director for AHPs Assistant Director for Operational area Co-Director	Trust AHP Lead Assistant Director	
Senior mgt scale (not AfC)	Director	Director	
Other relevant AHP posts (some outside of HSC)			
	Lead AHP Officer (DoH) Assistant Head of CEC (Band 8a) AHP Training Consultant – Supervision Training (Band 7 temporary)		

**Band 6 – not recognised as advanced practice

Proposed working title for Band 6 –'Specialist' (noting recognised profession i.e. Specialist Physiotherapist)

Would have a higher degree of autonomy than Level 5 in the clinical environment. Working autonomously with freedom to exercise judgment about actions guided by professional accountability and responsibilityMinimum 2 years' experience required with relevant postgraduate experience, education and training equivalent to postgraduate certificate level

	Level of competency	Outputs – what the job will deliver
	Dependent on post requirements, responsibility and accountability	Lead professional development and quality improvement planning across a Trust reflecting the importance of values based approaches Act as a champion and role model for AHPs Demonstrate knowledge of health improvement programmes, planning of services through implementation and evaluation

**Band 5 – not recognised as advanced practice

Proposed working title – HCPC registered title (Physiotherapist, Radiographer etc.)

Additional notes
If a profession is unable to recruit at a particular band they may re-advertise at a lower band and note that the post holder will remain at the lower band until they meet the required postgraduate experience and demonstrate the competencies for the next level at the higher band.

Clinical or strategic reasons may affect the number of years' experience or qualifications required.

Any changes to agreed job titles and essential criteria will start after the framework is formally launched – this would apply in a 'going forward' approach and should have no regrading implications. The key purpose of an agreed 'working title' is to have less confusion in the system and with service users. The titles suggested would be an umbrella term which would cover the job profiles and will not affect AfC.

Appendix 4

ADVANCED PRACTITIONER PROFILES

ADVANCED PRACTITIONER LEVEL 1

Jane Beggs

BSc (Hons) Podiatry

Podiatrist Band 7

Current Title:
Advanced Clinical Specialist, Diabetes

Northern Health and Social Care Trust

Context

Diabetes and diabetic foot disease is an increasingly urgent health issue. The Quality Outcomes Framework identifies that 84,836 people in Northern Ireland have diabetes and approximately 15% of people with diabetes will develop a diabetic foot ulcer within their lifetime.

Diabetic foot disease is one of the most distressing and disabling complications of diabetes. Every week there are four leg, foot or toe amputations carried out on people in Northern Ireland. It's the aim of regional podiatry services to develop and implement agreed guidelines to address this and reduce the rate of ulceration and amputations.

Role

The Advanced Clinical Specialist ensures the provision of a professionally competent podiatry service to patients with diabetes. This role is becoming increasingly specialised with emphasis on wound management and the prevention of serious foot pathologies.

The Advanced Podiatrist uses his/her initiative to develop and interface with the multidisciplinary team members. In conjunction with colleagues and podiatry management the Podiatrist will contribute to the development of diabetes services Trust-wide and will provide a mentoring role for staff in the management of foot pathologies associated with diabetes.

How it has helped

This role has played an integral part in the establishment of an Enhanced Foot Protection Team (EFPT) in Causeway Hospital.

The objectives are to streamline and enhance foot care pathways and establish a multidisciplinary team to manage active foot disease and cardiovascular risk, to ensure early intervention within 48 hours, as per Nice Guideline 19.

The EFPT reduces emergency admissions and visits to ED and supports service users to self-manage.

At the end of year two of the project, results showed:

- 493 referrals were received for active wounds to the EFPT;
- 85% were seen within 48 hours;
- 70% reduction rate in amputations;
- an approximate saving of £98,000 through avoiding 504 bed days by using the hospital diversion team and therefore keeping the patient in their own home.

ADVANCED PRACTITIONER LEVEL 1

Audrey Browne
BSc (Hons) Radiography

Band 7

Current Title:
Clinical Specialist Ultrasonographer
PGD Ultrasound
MSc Radiation Science (US Ultrasound)

Western Health and Social Care Trust

Context

Ultrasound is a key primary diagnostic tool. It is used largely for imaging of soft tissue structures e.g. liver, kidney, obstetrics etc.

Increasingly patients referred to the radiology service for ultrasound are usually scanned by a sonographer who produces an independent report.

Prior to the roll out of clinical specialist sonographers the scan would have been undertaken by a sonographer, who provided a descriptive report and this would have been reviewed and signed off by a Radiologist. This practice still continues for specific or complex cases.

In radiology departments the ultrasonographers are qualified state registered Radiographers who will hold a BSc in Radiography (or equivalent) as well as a postgraduate certificate or diploma in medical ultrasound.

In order to practise as an ultrasonographer, a practitioner will have extensive knowledge of the physics of ultrasound, anatomy, physiology and disease processes as well as several years' training and mentorship. Within ultrasound there is a range of subspecialty areas of scanning which include musculoskeletal, vascular and obstetrics.

The term sonographer is not a 'protected title' but The College of Radiographers administers a Voluntary Register of Sonographers.

Role

The ultrasonographer provides a high level of clinical expertise in the performance of ultrasound scans as well as the issue of an independent report.

Often, particularly in subspecialty areas, the sonographer will have a clearly defined scope of practice which is subject to reflection, audit and peer review to ensure maintenance of the highest possible standards of care.
The majority of sonographer-led ultrasound scanning takes place in the acute setting, i.e. hospital based, although there is interest in providing these services in non-acute settings e.g. GP practices or community settings. The role involves close partnership working with Radiologists and other health care professionals to ensure maximum benefit for patients.

How it has helped

Radiographer-led ultrasound services are well established in all of the acute sites in NI.

In WHSCT there is a Radiographer-led, seven-day ultrasound service, which has allowed a complete redesign of the delivery of ultrasound.

By increasing the number of Advanced Practitioners, the service revised the appointment schedules and moved routine scanning to Saturday and Sunday. This freed up space during the week for unscheduled and emergency scanning and allowed inpatient scanning to continue on a seven-day basis.

Feedback from patients has been very positive and the workflow during the week has become much more balanced. There was also a reduction in the lengths of stay for inpatients. Staff also saw benefit as they were able to deliver timely care, under more controlled conditions.

ADVANCED PRACTITIONER LEVEL 1

Jenny Kirkwood

Band 7

Current Title:
Music Therapy Manager

Context

In Northern Ireland Music Therapy services are currently provided by contractors external to the HSC Trusts.

One such organisation is a charity with a team of 10 therapists, including two Music Therapy Managers. Music Therapists are employed at Band 6 equivalent and are managed by the two Music Therapy Managers in Band 7 equivalent posts.

They therefore work at an advanced practice level supporting a team of therapists in delivering effective Music Therapy practice across Northern Ireland.

Role

In this organisation, the Music Therapy Managers' role encompasses clinical, managerial and research areas to ensure the efficient running of therapy services provided to service users, both in HSC Trusts and in private contracts. This includes overseeing therapists' caseloads, providing training, monitoring therapy processes, and quality assurance.

They use their own up-to-date knowledge of current practice and evidence, and advanced practice experience to provide guidelines, policies and procedures as well as supervision to guide and support staff in continuously improving their therapy practice.

They also engage in ongoing research projects liaising with universities and partner organisations and overseeing the therapists involved, thus contributing to the evidence base for their profession. As part of quality assurance, they have developed and implemented the organisation's outcomes-based accountability procedures.

How it has helped

The main impact of this role in recent times has been the development and improvement of existing quality assurance processes in the organisation – including audits, appraisal system, clinical guidelines and procedures, risk assessments, and outcomes-based accountability incorporated into the therapy process.

There is a benefit for all staff in the increased effectiveness of their own working practices, with clear benefit then passed on to service users as they are receiving high quality, best-practice therapy at all times. This continuous improvement approach has been reflected in consistently positive outcomes measured and positive feedback in customer service evaluations.

ADVANCED PRACTITIONER LEVEL 1

Catherine Page

Band 7

Current Title:
Specialist Paediatric Orthoptist Band 7

Southern Health and Social Care Trust

Context

This role was created to provide a specialist Orthoptic service for children with special educational needs and disability throughout SHSCT.
There was need to provide a source of expertise on the management of children with special needs and provide an advisory, education and consultative service to parents, teachers and other health professionals and appropriate stakeholders that could not be accommodated within the constraints of a core service.

The post holder is responsible for planning and delivering the Orthoptic service within the existing multidisciplinary teams.

Role

The Specialist Paediatric Orthoptist provides a high level of clinical expertise in the assessment, diagnosis and management of children with special educational needs and disabilities.

This includes children with physical disability, learning difficulties/disability, sensory dysfunction and other long-term conditions.

Many of these children will present with very challenging behaviour.

This post is mainly school-based allowing the Orthoptist to assess the functional needs of each individual child and recommend specific treatment or strategies tailored to the needs of the individual within their academic environment, allowing them fuller access to the education curriculum. The Orthoptist plays a pivotal role in providing advice and support to parents, AHPs and educators.

How it has helped

Attendance at core Orthoptic clinics by this specific client group was recorded at 50% due to high levels of sickness and a prioritisation of other appointments by parents.

Catherine is able to assess, treat and manage children within the school setting thereby offering a specialised assessment without the need for additional clinic/hospital appointments.

Catherine is also able to give practical support to the multidisciplinary team within the school setting.

Parent satisfaction questionnaires recorded that 100% of parents felt that it was more beneficial for their child to access the Orthoptic service within the school setting rather than in the hospital setting. Some 83% of parents recorded that the report sent home following assessment was either helpful or extremely helpful and increased parental understanding of their child's visual needs.

Teacher questionnaires recorded similar high levels of satisfaction both with the benefits and outcomes of having a specialist Orthoptic school service.

ADVANCED PRACTITIONER LEVEL 1

Joy Whelan

BSc (Hons) Nutrition & Dietetics

Band 7

Current Title:
Advanced Coeliac Specialist Dietitian, Band 7

Western Health and Social Care Trust

Context

Coeliac disease affects up to 1% of the population.
Current national diagnosis rates are estimated to be 0.25% in the UK resulting in an estimated half a million people remaining undiagnosed. Figures in the WHSCT calculate a diagnosis rate of 0.63% with the current register having 2,100 patients.

Approximately 75 patients are newly diagnosed per year. Guidelines recommend long-term follow-up of all patients with coeliac disease. In 2012, lengthy coeliac review waiting lists existed for the Consultant Gastroenterologist in the WHSCT with nearly 400 patients overdue their Consultant appointment.

Role

The Advanced Coeliac Specialist Dietitian now works at an advanced practice level, acting as an expert nutrition and dietetic resource facilitating learning in coeliac disease.

Dietetic-led coeliac clinics were set up which allows patients to have just one holistic appointment rather than separate doctor and dietitian appointments. The appointment includes assessing symptoms, obtaining and assessing relevant blood measurements, ordering and reading relevant bone scans, as well as providing updated advice on the gluten-free diet and products, prescription information, Coeliac UK membership advice etc.

Skills required for undertaking the post included having extensive experience and knowledge of coeliac disease and gastroenterology, shadowing of the Consultant Gastroenterologist and completion of the BDA/ Coeliac UK Coeliac Update course. An understanding of current guidance on pneumococcal vaccination, medical imaging referral guidelines and bone scan interpretation was also needed. Training and competence were also achieved in venepuncture techniques.

How it has helped

An audit of the service shows it is an efficient and cost-effective method of review for this patient group with clinics costing 50% less than Consultant clinics and patient satisfaction of more than 90%.

Any patient who needs a Consultant Gastroenterologist review can also then be seen without delay. In addition to this, approximately 70% of newly diagnosed patients, those aged under 50, are booked directly to the clinic in place of a new patient slot being needed in the gastroenterology clinic. There is a potential improvement to adherence to the gluten-free diet and reduction of complications compared to those not reviewed e.g. all adult patients receive an initial bone scan when newly diagnosed and audit shows 47% of these patients were diagnosed with osteopenia/osteoporosis. In a separate audit 45% of patients tested had a low vitamin D status and would risk bone complications unless supplemented.

As a result of this role, improvements have been achieved in terms of timely review of patients, release of Consultant time and increased patient satisfaction, alongside long-term cost savings.

It was also found that 35% of patients with coeliac disease had been lost to follow-up in the northern sector of the WHSCT. They are being invited back to re-engage with the service, which will provide support to this patient group as well as reducing their risk of complications and ultimately the cost to the NHS.

ADVANCED PRACTIONER LEVEL 2

Mary McGrath
MPhil, Dip COT, RCOT, MAOTI

Band 8A

Current Title:
Advanced Clinical Specialist Occupational Therapist, Memory Clinic

Belfast Health and Social Care Trust
Advisor to Alzheimer Scotland

Context

Following receiving ethical approval from Queen's University Belfast, Mary won a research bursary (MPhil) to carry out a randomised, single-blind controlled trial at Ulster University. The Home-based Memory Rehabilitation Programme (HBMRP) was launched in January 2007 providing memory rehabilitation to service users with early-stage Alzheimer's disease and other dementias.

The aims of the programme are to teach people to compensate for their everyday memory difficulties, support independence and human occupations, increase resilience and reduce caregiver burden.

In 2013, the British Medical Journal commissioned an article on safety in the home for people with dementia.

Mary presented at many dementia conferences and meetings training colleagues all over Ireland and at the Royal College of Occupational Therapists and was invited to deliver another Master Class in the Royal College in October 2018. She will also deliver it on Shetland Island for all the senior Occupational Therapists involved in the early treatment of dementia in the Scottish Islands.

Following the completion of her MPhil, she undertook Chief Investigator training and now is the AHP representative on the Northern Ireland Dementia Research Network where she will have a vote for the approval and adoption process of all dementia research carried out in Northern Ireland.

In 2016 and 2017, she presented papers to the Royal College of Dentists in Belfast and Edinburgh on the management of the dementia patient in the dental surgery.

She currently teaches on the undergraduate Occupational Therapy course in Ulster University and the undergraduate/postgraduate medical course in Queen's University Belfast.

Role

The Occupational Therapy-led MRP was, therefore, developed to address these functional and behavioural issues. This programme, which was adapted from cognitive rehabilitation principles for brain injury, teaches people, most of whom have a primary diagnosis of mild cognitive impairment or dementia, strategies to compensate for their everyday memory difficulties whilst adapting the home environment to support these strategies. It is a six-week, customised, home-based programme involving the primary caregiver, where possible. Regular review takes place following the programme to ensure that the compensatory strategies are still being used and to provide caregiver support.

How it has helped

Various aides-memoires are used to support orientation for time and place, episodic memory, medication management, route finding, home safety, scheduling, self-confidence and the reduction of behaviours that cause agitation with a subsequent rise in caregiver burden.

The role of the Occupational Therapist has expanded into facilitating both the early diagnosis of dementia and differential diagnosis by identifying those who present with dementia-like symptoms but who have memory problems for different reasons. The functional and cognitive assessments form part of the triangulation approach to diagnosis, which also includes medical assessment and specialist brain scanning, including PET-CT. A comparison of the results of the main outcome measure the Rivermead behavioural memory test-11 (RBMT-11) was compared by this therapist and a Consultant Neuro-radiologist with PET-CT scan results. This demonstrated that results of the RBMT-11 corroborated the PET-CT scan results, thus further validating the use of this outcome measure for the diagnosis of Alzheimer's disease and other dementias and strengthening the role of the Occupational Therapist in the diagnostic process. As a result of this clinical audit, this Occupational Therapist attends and contributes to the monthly, Trust-wide PET-CT Consultant's meeting for dementia diagnosis and treatment planning.

ADVANCED PRACTITIONER LEVEL 2

Fionnula Mann
MSc, BSc (Hons) Speech and Language Therapist MRCSLT

Band 8A

Current Title:
Advanced Clinical Specialist Speech and Language Therapist, Videofluoroscopy Clinic, Ulster Hospital,

South Eastern Health and Social Care Trust

Context

Videofluoroscopy (VFS) is the modification of the standard barium swallow examination used in the assessment and management of oropharyngeal swallowing disorders.

Speech and Language Therapists play a key part in delivering VFS services for adults in a multidisciplinary context.

Traditionally VFS clinics were Radiologist led, however, the clinic based in the Ulster Hospital progressed to practitioner-led clinics approximately 15 years ago. In consultation with the Radiology department and Trust management and acknowledging IR(ME)R guidelines, clear roles and responsibilities within the confines of the VFS clinic were established.

The establishment of a practitioner-led clinic has greatly improved patient access to this vital examination, with approximately 150% increase in access to this clinic. While waiting times for inpatients has decreased considerably, outpatient waiting times have remained static but this correlates to the increased demand for this service.

Role

The Speech and Language Therapy adult service within the South Eastern Trust delivers care to adult clients presenting with communication and swallowing disorders providing a comprehensive service in terms of assessment, diagnosis and treatment.

All Speech and Language Therapists working in the area of dysphagia have background training in the interpretation of VFS studies to inform their clinical assessment and management. Fionnula Mann has completed a

number of postgraduate training courses which has equipped her to lead the VFS clinic.

Specific VFS training was undertaken in the Adelaide and Meath Hospital between 2009 and 2010. This master's level course specifically focused on the VFS analysis in adult dysphagia and it consolidated her skills in recognising the indicators for VFS, understanding the procedure itself, identifying the anatomical and dynamic abnormalities in the swallow function, the reporting of findings and finally the development of an appropriate therapeutic intervention/rehabilitation programme. In addition, and in line with Trust requirements, Fionnula has undertaken IR(ME)R training, specifically in the areas of the biological effects of ionising radiation and the risks and benefits to its use, patient dosage and measurement, and roles and responsibilities of key personnel.

Fionnula also completed her master's in Advanced Clinical Practice with Special Study in Speech and Language Therapy in 2014.

How it has helped

Dysphagia has been identified as a significant risk for increasing numbers of adult clients living within Trusts. The need to deliver services to address the growing demands is essential and advanced dysphagia training for Speech and Language Therapists allows the profession to ensure that clients receive the best targeted interventions as early as possible. In accessing specialist Speech and Language Therapy input, clients are managed much more safely with fewer complications.

The development of a practitioner-led VFS clinic is part of a much wider service aimed at delivering quality, timely services to clients presenting with swallowing difficulties. The rise in dysphagia related critical incidents has resulted in the need to review all aspects of the continuum of care delivered to this client group from frontline MDT management, to access objective assessment to quickly diagnose issues, through to management both within and outside the Speech and Language Therapy profession.

ADVANCED PRACTITIONER LEVEL 2

Helen Vennard
MSc Medical Science,
BSc (Hons) Radiography

Band 8A

Current Title:
Principle Clinical Specialist Radiographer
Breast and Gynae Cancer (CSSR)

Belfast Health and Social Care Trust

Context

The scope of practice for an individual does not remain static but continually evolves and is defined and evidenced by the competencies they achieve. Radiographers have been successfully expanding and diversifying their roles within Radiotherapy and adapting to the ever-changing technological demands.

The report from the National Radiotherapy Advisory Group states that redesign of the workforce should be based on skills rather than job titles and 80% of practice could be managed by non-medical Advanced/ Consultant Practitioners.

Role

The CSSR role was initially designed to help streamline the co-ordination of planning and treatment pathways. Role development and development of radiotherapeutic practice was also a key component.

Helen has developed expert theoretical knowledge of breast and gynaecological cancers (including aetiology, treatment rationale and a detailed knowledge in therapeutic technique). Currently Helen is competent to undertake new patient consultations, including history taking, discussion pertaining to multi-modality treatment options, and explanations of the treatment management plan to the patient and their family. These skills are completely transferrable and interchangeable between both the breast and gynae site specialties. As expert knowledge and experience has developed, this role has further progressed.

In 2010, the Department of Health commissioned places for non-medical prescribing (NMP) for Radiographers. Having attained the NMP qualification has allowed Helen to set up a weekly treatment review clinic to manage treatment related toxicity and subsequently prescribe for both these groups of patients within the hospital setting or in communication with primary care. Helen also coordinates a weekly review meeting to ensure discussion of patients, their management and to ensure continuity of care with the multidisciplinary team.

Radiotherapy for breast cancer accounts for approximately 30% of all Radiotherapy treatments delivered. At the Cancer Centre in Belfast, 80–100 patients with breast cancer are planned for Radiotherapy each month.

Helen is currently piloting a quality improvement prototype (CSSR-led breast planning). Helen successfully completed a distance learning MSc module in expert practice in breast planning, through Sheffield Hallam University. Completion of this course of study allows her to plan breast cancer treatments and make the transition from a medically led model of care, to a non-medically led and supported model.

How it has helped

An audit of NMP of 51 reviews demonstrated 74.5% were carried out by the CSSR, 1.9% was joint review and 23.5% were clinician review. This equates to approximately six hours of time per week for patients reviewed by the CSSR.

When the quality improvement prototype is rolled out the benefits will include increased time for clinicians to manage complex cases, an opportunity for the CSSR to drive changes in service delivery, equipment optimisation and improved equity and access for all patients.

CONSULTANT AHPs

Vicki Quinn

BSc (Hons) Physiotherapy

Band 8B

Current Title:
Consultant Physiotherapist

Western Health and Social Care Trust

Context

An estimated 29% of the total UK population live with a musculoskeletal (MSK) condition.

It is suggested that one in five people attend their GP every year with a MSK problem, accounting for up to 30% of a GP's caseload.

In parallel with changes in the MSK health of the population, are the acknowledged workforce issues within general practice. The training, recruitment and retention of GPs is recognised as a significant challenge to effective general practice provision and to maintaining sustainable workload.

In the Western Trust, the implementation of Orthopaedic ICATS and the integrated MSK Pathway model has already significantly changed MSK management towards secondary care over the last 10 years. The pilot of First Contact Physiotherapy (FCP) posts, which are already operational in England, Scotland and Wales, was implemented in January 2018 to test FCP in the local context.

Role

The expectation of the FCP role in primary care is that patients (> age 16) presenting with undiagnosed MSK conditions will be assessed, diagnosed, offered initial treatment/management advice, including self-management, and discharged or referred onwards, if required. This may include referral for investigations such as x-ray, MRI or blood tests.

The FCP works at an advanced level within a bio-psycho-social model, to manage complexity, multi-factorial health conditions and risk. Training enables recognition of, and response to, the possibility of serious pathology, differential diagnosis, and consideration of the impact of individuals' clinical status on their overall health and well-being.

Vicki has extensive experience having completed a wide range of postgraduate physiotherapy training, including Society of Orthopaedic Medicine, Maitland and McKenzie concepts, and in management of persistent pain. She has completed a master's programme in First Contact Care/Advanced Practice, and a postgraduate Certificate in Rheumatology. Vicki is also a non-medical independent prescriber. For future FCP posts, it will also be desirable to be trained in injection therapy. Other training includes referral for imaging and blood tests and shadowing orthopaedic consultants and GPs.

How it has helped

Evaluation of the FCP project has shown that a Physiotherapist working at an advanced level in a GP practice can reduce attendances to GP appointments by patients with MSK conditions.

Many people with MSK conditions (48%) simply need expert assessment, reassurance, advice on exercise or activity, self-management strategies and perhaps social prescribing, to set them on the road to recovery, without the need for onward referral.

For patients who are referred for physiotherapy management or to orthopaedics for surgical opinion, advice is given to continue with active management while waiting to be seen. FCP also streamlines pathways, which reduces unnecessary costs.

Satisfaction surveys showed that patients placed significant value on seeing an MSK specialist, and that FCP is acceptable to GPs as an addition to the practice team and expertise.

The vision for primary care in Northern Ireland supports an integrated approach to service delivery, based on multidisciplinary teams embedded in primary care.

CONSULTANT AHPs

Donna Kerlin, BSc (Hons) Radiography

Band 8B

Current Title:
Consultant Radiographer (Breast Services)

Western Health and Social Care Trust

Context

This is a new role designed to support breast services. Radiology is a key element of a multidisciplinary team delivering breast care for patients. The service has two major elements: breast screening, which sees women invited for triennial mammography between the ages of 50 and 70, and symptomatic services, which are provided for patients presenting with potential breast cancer following referral by their GP or hospital Consultant.

The Consultant Radiographer role was developed in WHSCT as a result of a chronic radiology staffing issue (national and regional) and a desire to complete the introduction of a four tier Radiography service in line with Department of Health, HSCB and College of Radiographers proposals.

The Breast Consultant is a state registered Radiographer who holds a BSc in Radiography, a postgraduate Certificate in Mammography, and years of experience at Advanced Practitioner (Clinical Specialist) level. In addition, the Breast Consultant will hold a master's level qualification in image interpretation and reporting, Master's level qualification in breast biopsy and a master's level qualification in breast ultrasound.

Role

The Consultant Radiographer is required to provide a wide range of radiological expertise to the service including:

- mammogram interpretation and reporting;
- performance of vacuum assisted core biopsies; and
- ultrasound of the breast including fine needle aspiration, wide bore needle biopsies and breast cyst aspiration.

In addition there is a requirement for participation in research, audit and multidisciplinary meetings, as well as mentorship and training of other Level 1 Advanced Breast Clinical Specialist Radiographers.

How it has helped

Although this is a new role the Consultant has already made significant progress in supporting the breast service in WHSCT. On completion of training and an extended period of mentorship, the Consultant Radiographer will be responsible for providing Consultant Radiologist level support for identified aspects of the breast service.

This will result in:

- 25% of post screening clinics and 40% of symptomatic clinics being supported by the Consultant Radiographer; and
- a reduction in the number of additional waiting list clinics being held in WHSCT.

Once established it is proposed that the Breast Consultant Radiographer would be instrumental in supporting other advanced breast practitioners in training as well as looking at service redesign with a view to a reduction in overall waiting times for patients identified as routine. All other cases are potentially cancer and are seen within the 14 day target

Appendix 5

Membership of Steering Group

Hazel Winning (Chair)	AHP Lead Officer DoH
Carmel Harney (Chair 2016)	Assistant Director of AHP Governance, WFD and Training SHSCT
Maxine Williamson	Project Lead Leadership Centre
Paul Rafferty	Trust AHP Lead WHSCT
Paula Cahalan	Trust AHP Lead BHSCT HSCT
Jill Bradley	Trust AHP Lead NHSCT
Eamon Farrell	Acting Assistant Director of AHP Governance, WFD and Training SHSCT
Margaret Moorehead	Assistant Director of AHP, SEHSCT
Michelle Tennyson	Assistant Director AHP Public Health Agency
Maura Mallon	Directors of Human Resources Forum
Peter Barbour	WPD DoH
Pauline McMullan	Clinical Education Centre
Jane Hanley	AHPFNI
Patricia McClure	Ulster University
Patrick Convery	RQIA
Sara Lappin	Service User Rep

Appendix 6

Membership of Working Group

Paul Rafferty (Chair)*	Head of AHP Services, Western Trust
Peter McAuley	AHP Deputy Principal DoH
Maxine Williamson*	Project Lead, HSC Leadership Centre
Kevin McAdam	Staff Side Representative UNITE
Ruth Watkins	Staff Side Representative UNISON
Jenny Kirkwood	Music Therapy
Dan McLaughlin*	Radiology
Lorraine Coulter	Speech and Language Therapy
Alison Campbell-Smyth*	Podiatry
Shane Elliott	Occupational Therapy
Paddy McCance	Orthoptists
Elaine McConnell	Physiotherapy
Jonathan Bull	Prosthetists and Orthotists
Mandy Gilmore	Dietetics
Patricia McClure	AHP School UU

Co-produced across all AHP/Hos professions

* Members of the sub-group which developed the content of the Advanced AHP Practice Framework.

References

Bengoa, R. (2016) Systems, Not Structures: Changing Health & Social Care. Belfast: Department of Health.
Available at:
https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf

Department of Health (2004) The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process. London: Department of Health.
Available at: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843

Department of Health (2016) Health and Wellbeing 2026: Delivering Together. Belfast: Department of Health.
Available at:
https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

Department of Health (2016) Health and Social Care Workforce Strategy 2026. Delivering for our People. Belfast: Department of Health.
Available at:
https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

Department of Health Social Services and Public Safety (2014) Supporting Leadership for Quality Improvement and Safety: An Attributes Framework for Health and Social Care. Belfast: Health and Social Care Board and Public Health Agency.

Department of Health Social Services and Public Safety (2014) Regional Supervision Policy for Allied Health Professionals. Working for a Healthier People
Available at:
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/regional-supervision-policy-ahp-2014.pdf

Department of Health Social Services and Public Safety (2012) Improving Health and Well-Being Through Positive Partnerships. A Strategy for the Allied Health Professionals in Northern Ireland
Available at: https://www.health-ni.gov.uk/publications/improving-health-and-well-being-through-positive-partnerships-strategy-allied-health
Accessed 30/01/2019

Dorset HealthCare University NHS Foundation Trust (Generic Job Descriptions November 2016)

National Executive Scotland (2007) Advanced Practice Themes Developed from NES
Available at: http://www.advancedpractice.scot.nhs.uk/media/1248/advanced%20practice%20themes%20and%20underpinning%20principles%20(3).pdf

National Health Service Leadership Academy (2013) Healthcare Leadership Model.
Available at: http://www.leadershipacademy.nhs.uk/discover/leadership-framework
Accessed on 4 February 2014

National Leadership and Innovation Agency for Healthcare (2010) Framework for Advanced Nursing, Midwifery and Allied Health Professional Practice in Wales.
Available at: http://www.wales.nhs.uk/sitesplus/documents/829/NLIAH%20advanced%20Practice%20Framework.pdf
Accessed on 22 July 2013

NHS Education for Scotland (2012) AHP Advanced Practice Education and Development Framework (Musculoskeletal)
Available at:
http://www.ahpadvancedpractice.nes.scot.nhs.uk/media/251474/msk%20framework%20(final).pdf
Accessed 30/01/2019

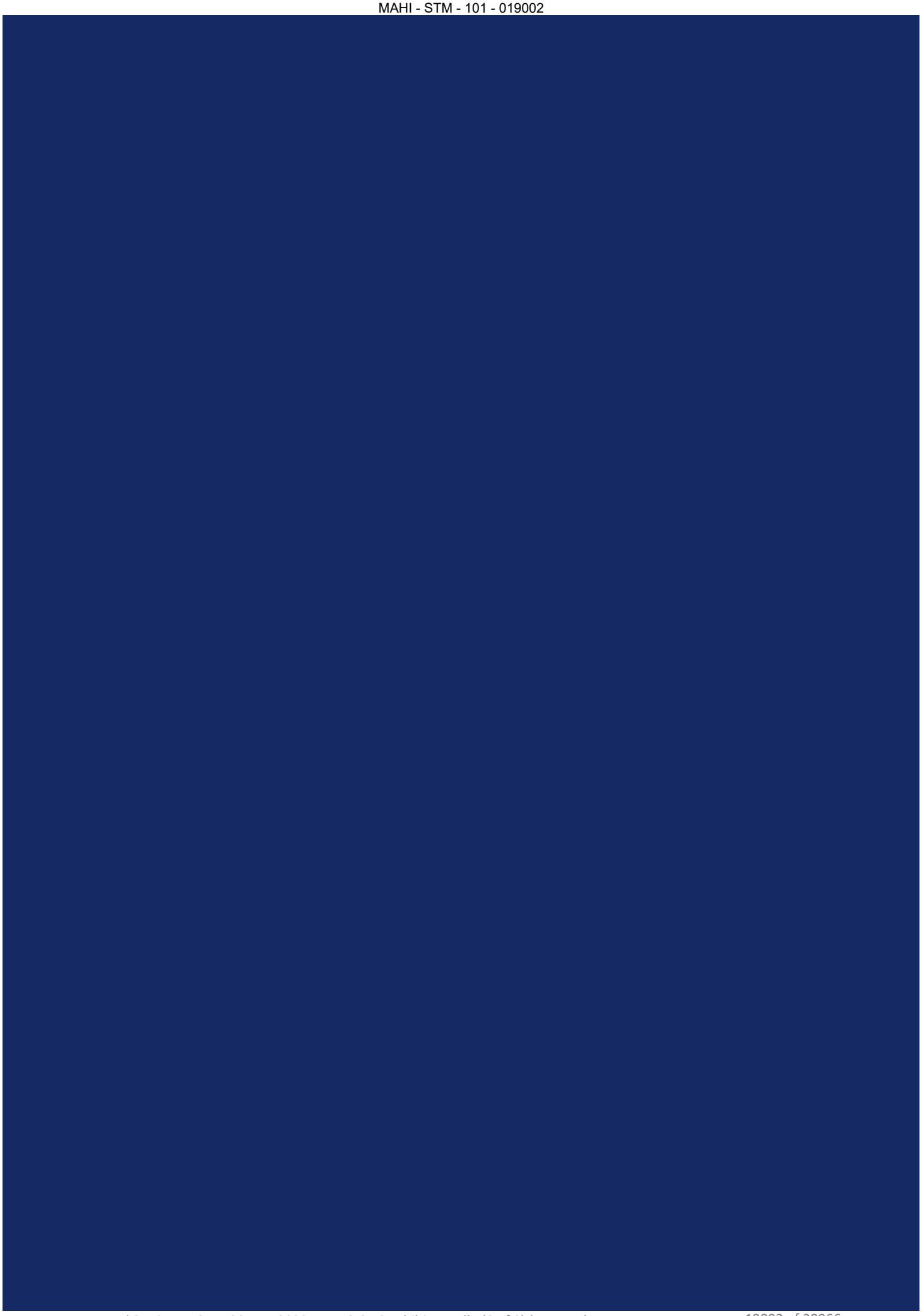
NHS Employers (2018) NHS Terms and Conditions (AfC) Pay Scales 2018/2019
Available at: https://www.nhsemployers.org/your-workforce/pay-and-reward/agenda-for-change/pay-scales

NHS England (2015) Advanced Clinical Practice Framework for the West Midlands
Available at: https://www.hee.nhs.uk/sites/default/files/documents/West%20Midlands%20Advanced%20Clinical%20Practice%20Framework.pdf
Accessed 30/01/2019

NHS HEE (not dated) Advanced Clinical Practice.
Available at:
https://www.hee.nhs.uk/our-work/advanced-clinical-practice

HCPC (2016) Standards of Conduct, Performance and Ethics
Available at: https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
Accessed 30/01/2019

The Quality Assurance Agency for Higher Education (2010) Master's Degree Characteristics
Available at: https://dera.ioe.ac.uk/5/1/MastersDegreeCharacteristics.pdf
Accessed 30/01/2019



Principles for **continuing professional development** and lifelong learning in health and social care

Prepared by:
The Interprofessional CPD and Lifelong Learning UK Working Group

January 2019

Acknowledgements

We would like to thank Sue Russel (National Education Administrator, College of Paramedics) for her administrative support throughout this project. We would also like to thank the design team at the Royal College of Occupational Therapists for designing this document, and the College of Paramedics Board of Trustees for funding and supporting this initiative. We are grateful to the professional bodies and organisations that hosted meetings throughout the project and to all stakeholders that provided feedback.

The Allied Health Professions Federation (AHPF) have reviewed this document and offer their full support of the principles for continuing professional development and lifelong learning in health and social care.

Contents

Definitions

Continuing professional development (CPD)

The way in which you continue to learn and develop throughout your career. CPD is essential. It adds to your skills, knowledge, professional identity and ways of thinking so that you stay up to date and practise safely and effectively, now and in the future.

Lifelong learning

Formal and informal learning opportunities that allow you to continuously develop and improve the knowledge and skills you need for employment and personal fulfilment.

Service user

Anyone who uses or is affected by your services, for example, patients, clients, carers, families, students, volunteers, staff members or colleagues.

Wider system

Any group or organisation that supports, provides the resources for or governs the health and social care workforce, for example, UK administrations, professional bodies and associations, service user groups, trade unions, other service providers and regulators.

Health and social care workforce

Everyone who works in the health and social care workforce, including in research, education, leadership, management and clinical practice. This covers all sectors and settings, both public and private and across the community.

Introduction

The principles outlined in this document have been agreed by the organisations represented within the Interprofessional Continuing Professional Development and Lifelong Learning UK Working Group (Membership list – Appendix A).
This document replaces the 'Joint statement on CPD for health and social care practitioners' published in 2007.

Continuing professional development (CPD) and lifelong learning are necessary for the development of everyone who works in health and social care and for the experience of service users. CPD and lifelong learning support a workforce that is capable of designing, delivering, evaluating and improving high-quality care and services.

The principles set out in this document should be applied across the health and social care workforce in all sectors, to support CPD and lifelong learning. Registered health and social care professionals also have a responsibility to meet the standards of their regulatory or professional body.

CPD and lifelong learning are each person's responsibility. Also:

- professional bodies and trade unions have a shared responsibility to promote CPD and lifelong learning to their members and provide guidance to support the highest standards of practice;
- employers have a responsibility to support you to take part in CPD and lifelong learning in line with regulatory, professional and UK health and social care system requirements (as well as any statutory and compulsory training requirements); and
- the wider system has a responsibility to promote and support fair access to CPD and lifelong learning opportunities as part of planning, developing and investing in a workforce.

By working together, the benefits will be felt across services and improve care and delivery.

The purpose of this document

CPD and lifelong learning drive improvement in how services are delivered and how the workforce is developed. This document sets out five high-level principles for the health and social care workforce across the UK and is designed for individuals, employers and the wider system.

You should use these principles alongside professional and regulatory standards. They are relevant to everybody who works in health and social care, and we encourage all organisations to follow them.

The five principles

CPD and lifelong learning should:

1. **Principle 1:** be each person's responsibility and be made possible and supported by your employer;
2. **Principle 2:** benefit service users;
3. **Principle 3:** improve the quality of service delivery;
4. **Principle 4:** be balanced and relevant to each person's area of practice or employment; and
5. **Principle 5:** be recorded and show the effect on each person's area of practice.

These principles reflect shared responsibilities for:

- **you** to recognise and demonstrate the effect of CPD and lifelong learning on practice (see reference 1 on page 14);
- **your employer** (if this applies) to actively invest in people and provide opportunities for CPD and lifelong learning; and
- **the wider system** to support the health and social care workforce and improve the safety and quality of services by investing in and developing the workforce.

The importance and benefits of CPD and lifelong learning

Service users expect individuals and teams to have and use up-to-date knowledge, understanding and skills appropriate to their area of practice.

The health and social care workforce operates in a constantly changing, challenging and complex environment. Developing new knowledge, skills and ways of thinking will help you to accept new and flexible ways of working which are based on evidence, and contribute to improving services. To do this, there needs to be investment in effective, supported and quality CPD and lifelong learning for everybody.

A shared commitment to developing a well-resourced and effective workforce will improve the quality of service delivery, improve outcomes and reduce risk.

The table below lists the benefits of CPD and lifelong learning to **you, service users and organisations.**

Encourages a positive learning culture
Improves skills, knowledge, and ways of thinking and working
Makes you feel valued, motivated and confident
Develops your career and helps you to move between sectors and roles
Makes you feel able to drive change and innovation
Means you remain fit to practise and meet regulatory body standards (including codes of conduct)
Keeps you up to date with changing technology and service demands
Improves experience and outcomes
Makes you feel safe and confident in the services provided
Increases satisfaction with services
Contributes to up-to-date and evidence-based services
Influences service development
Improves the quality of service delivery
Supports recruitment, keeping staff, and creating a flexible workforce
Adds to the mix of skills and productivity of staff
Improves performance

1 **Principle 1:** CPD and lifelong learning should be each person's responsibility and be made possible and supported by your employer

You	You are responsible for regularly planning, prioritising, carrying out, applying and reflecting on CPD and lifelong learning. You appreciate and recognise that valuable learning can happen in both planned and unplanned situations. You are responsible for identifying and demonstrating the benefits of learning to influence and gain support from your employer (if this applies).
Your employer	Has a responsibility to make sure that you are safe, up to date with current practices and can meet the needs of service users, in line with your professional standards. Provides fair access to time, study leave and funding to allow you to: • plan learning • carry out learning, and • think about the outcomes of learning. Encourages and supports access to learning that is separate to statutory and compulsory training, for the benefit of service users. Provides and supports access to resources (for example, technology) when they are needed.
The wider system	Is responsible for creating and promoting opportunities for integrated learning across teams.

2 **Principle 2:** CPD and lifelong learning should benefit service users

You	Your learning should develop new knowledge and skills, add to your existing skills, and provide opportunities to initiate and reinforce best practice. Your learning should be relevant to the needs of your service users or your employer (or both) and used in your area of practice.
Your employer	Is responsible for identifying the needs of service users to guide how relevant your learning is.
The wider system	Is responsible for supporting and promoting quality CPD and lifelong learning that benefits service users.

3 **Principle 3:** CPD and lifelong learning should improve the quality of service delivery

You	You explore and use ways to show how your learning has improved the quality of your practice. Your learning and the outcomes of your learning improve the quality of your service delivery and reduce risk. You identify opportunities to learn from and share learning with others.
Your employer	Encourages a culture of learning from experiences with positive outcomes, as well as from situations that did not go well. Supports learning opportunities between individuals, teams and networks, across services and organisations. Supports learning activity with time, staffing and resources to improve the quality of their service.
The wider system	Provides resources for quality learning through management, workforce and service delivery plans. Evaluates the effect of an appropriately qualified workforce on the quality of services. Has systems in place to assess the quality of CPD and lifelong learning activity.

4 **Principle 4:** CPD and lifelong learning should be balanced and relevant to each person's area of practice or employment

You	Your learning should include activities across the following four areas: • Health and social care • Learning and education • Leadership • Evidence, research and development. (Adapted from: NHS Education for Scotland, Four Pillars of Practice, 2012. See reference 2 on page 14). You take part in a range of learning activities, both formal and informal, as well as active and reflective (where you think about what you have learned). You take part in learning that is relevant to, challenges and develops your current or intended area of practice. Your learning meets relevant organisational, professional or regulatory standards.
Your employer	Recognises and supports learning across the following four areas: • Health and social care • Learning and education • Leadership • Evidence, research and development. Provides opportunities for a range of learning, including employees learning with and from each other. Responds to your learning needs within a constantly changing, challenging and complex environment.
The wider system	Promotes the value of a range of learning activities. Recognises and reinforces that the most important parts of learning are the outcomes.

5 **Principle 5:** CPD and lifelong learning should be recorded and show the effect on each person's area of practice

You	You are responsible for keeping a record of your learning that demonstrates: • what you learnt • how it adds to or develops your area of practice, and • the effect on service users or service delivery. You are responsible for accessing, promoting and using the resources available to you to support your CPD and lifelong learning. You are responsible for making sure you respect service users' confidentiality.
Your employer	Provides time, resources and opportunities to allow you to record and think about the outcomes of learning. Provides the opportunity to share the outcomes of learning across organisations. Has systems in place to monitor and audit fair access to CPD and lifelong learning activity.
The wider system	Raises awareness of existing and new resources to support recording and thinking about the outcome of learning.

Summary

This document continues a journey to develop and improve CPD and lifelong learning within the broader health and social care workforce. The principles will help to guide you, your employer and the wider system to encourage a culture of continuous improvement and workforce development for the benefit of those who use our services.

We will evaluate the effect of these principles to continue supporting the health and social care workforce with CPD and lifelong learning.

References

1. Health and Care Professions Council (2015). Our Rules for How Health and Care Professionals Behave. Available at: https://www.hcpc-uk.org/assets/documents/10004EE2Ourrulesforhowhealthandcareprofessionalsbehave.pdf Accessed 29 May 2018.

2. NHS Education for Scotland. (2012). Pillars of Practice. Available at: http://www.careerframework.nes.scot.nhs.uk/using-the-framework/pillars-of-practice Accessed 29 May 2018

Further resources

Academy of Royal Colleges. (2016). Core principles for Continuing Professional Development https://www.aomrc.org.uk/wp-content/uploads/2016/07/Core_Principles_CPD_0716-2.pdf

Aiken, LH. (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. The Lancet 383(9931): 1824–1830

Council of Deans of Health. (2016). Professor David Greatbatch – A false economy Cuts to Continuing Professional Development funding for nursing, midwifery and the Allied Health Professions in England https://councilofdeans.org.uk/wp-content/uploads/2016/09/19092016-A-False-Economy-CPD-cuts-in-England-2016-17-.pdf

Department of Health. (2013). A promise to learn – a commitment to act. Improving the safety of patients in England (2013) London, National Advisory Group on Patient Safety in England. https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office.

Government Office for Science. (2017). What are the wider benefits of learning across the life course? (2017) Foresight Future of Skills & Lifelong Learning project. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/635837/Skills_and_lifelong_learning_-_the_benefits_of_adult_learning_-_schuller_-_final.pdf

Health & Care Professions Council. (2015). Preventing small problems from becoming big problems in health and care. (2015) London, HCPC. http://www.hcpc-uk.org/assets/documents/10004A7EPreventingsmallproblemsfrombecomingbigproblemsinhealthandcare.pdf

The European Hospital and Healthcare Employers Association - European Public Service Union (2016) Joint Declaration on Continuing Professional Development (CPD) and Life-Long Learning (LLL) for All Health Workers in the EU. http://hospeem.org/wp-content/uploads/2016/11/Final-_Joint-Declaration-CPDLLL-08.11.2016-EN.pdf

Appendix A – List of Group members

Graham Harris (Chair)
National Education Lead
College of Paramedics

Will Broughton (Vice Chair)
Trustee Official for Professional Standards
College of Paramedics

Helen Chang
Head of Faculty and Foundation
Royal Pharmaceutical Society

Louise Coleman
Professional Officer for Education and Accreditation
The Society and College of Radiographers

Gill Coverdale
Professional Lead, Education Standards and Professional Development
Royal College of Nursing

Colin Crookston
Vice-Convenor
Allied Health Professions Federation Scotland

Mike Donnellon
Chair, Education and Standards Committee
College of Operating Department Practitioners

Thomas Elton
Professional Development Manager
The British Psychological Society

Dr Sally Gosling
Assistant Director, Practice & Development
Chartered Society of Physiotherapy

Victoria Harris
Learning Manager
The Royal College of Speech and Language Therapists

Kate Hon
BIOS Education and Professional Development Committee
British and Irish Orthoptic Society

Appendix A – List of Group members

Dr Val Huet
Chief Executive Officer
British Association of Art Therapists

Val Johnston
Assistant National Officer, Health Service Group
UNISON

Carmel Lloyd
Head of Education and Learning
The Royal College of Midwives

Lucie Nield
Education Board Member and Senior Lecturer
British Dietetic Association

Ethel Rodrigues
Lead Professional Officer (Education) Health Sector
Unite the union

Lynne Rowley
Executive Chair
The British Association of Prosthetists and Orthotists

Dr David Stirling
Executive Director
Association of Clinical Scientists

Dr Stephanie Tempest
Professional Development Manager
Royal College of Occupational Therapists

Alan Wainwright
Executive Head of Education
Institute of Biomedical Science

Grace Watts
Development Director
British Association for Music Therapy

Menna Wyn-Wright
Education Lead
British Dietetic Association

Appendix B – Contact details

Organisation	Website
Allied Health Professions Federation Scotland	http://www.nes.scot.nhs.uk/education-and-training/by-discipline/allied-health-professions/about-nes-allied-health-professions/ahp-directory/allied-health-professions-federation-scotland.aspx
Association of Clinical Scientists	http://www.assclinsci.org/acsHome.aspx
British Association of Art Therapists	https://www.baat.org
British Association for Music Therapy	https://www.bamt.org
British and Irish Orthoptic Society	https://www.orthoptics.org.uk
British Dietetic Association	https://www.bda.uk.com
Chartered Society of Physiotherapy	https://www.csp.org.uk
College of Operating Department Practitioners	https://www.unison.org.uk/at-work/health-care/representing-you/unison-partnerships/codp/
College of Paramedics	https://www.collegeofparamedics.co.uk
Institute of Biomedical Science	https://www.ibms.org
Royal College of Nursing	https://www.rcn.org.uk
Royal College of Occupational Therapists	https://www.rcot.co.uk
Royal Pharmaceutical Society	https://www.rpharms.com
The British Association of Prosthetists and Orthotists	https://www.bapo.com
The British Psychological Society	https://www.bps.org.uk
The Royal College of Midwives	https://www.rcm.org.uk
The Royal College of Speech and Language Therapists	https://www.rcslt.org
The Society and College of Radiographers	https://www.sor.org
UNISON	https://www.unison.org.uk
Unite the union	https://www.unitetheunion.org

Publisher information

Published in January 2019 by the College of Paramedics, The Exchange, Express Park, Bristol Road, Bridgwater, TA6 4RR.
Due for review: January 2021

Share your thoughts on how you use these principles with us via Twitter
#CPDTogether

Reference: Broughton W. and Harris G. (2019) (Eds.) on behalf of the Interprofessional CPD and Lifelong Learning UK Working Group. Principles for Continuing Professional Development and Lifelong Learning in Health and Social Care. Bridgwater: College of Paramedics.

What is the RCSLT CPD framework?

Broadly, it's a list of different CPD activities put into categories designed to help inform your CPD choices as part of planning your career development. These activities are relevant across the range of SLT workforce settings and are mapped to the NHS KSF. For each section of the framework core skills or a main focus for the CPD activities have been identified and these are in the table below.

The main category headings	Core Skills/ Focus within categories
1. Clinical reasoning and analysis	➢ Critical Reflection ➢ Planning (including evidence, experience and service user preference)
2. Ethical practice	➢ Equality & Diversity ➢ Client Autonomy
3. Research awareness, activity and engagement	➢ Critical analysis ➢ Data analysis
4. Human and financial leadership and resource management	➢ Influencing ➢ Strategic Thinking
5. Client-centred assessment and management	➢ Engagement with service users ➢ Enhancement of service delivery
6. Service planning and organisation	➢ Needs Assessment ➢ Data Evaluation
7. Accountability and performance governance	➢ Implementing governance/standards ➢ Developing quality assurance and standards
8. Communication	➢ Communication within the SLT workforce ➢ Strategic/external facing communication
9. Education & learning	➢ Growing and developing self ➢ Growing and developing others

Within these categories the activities have been divided into different types of CPD.

The activities are largely generic and relevant across the range of settings in which the SLT workforce provides services. We have included some commercial courses that we know SLTs will undertake as part of their CPD. These courses are only examples and their inclusion does not indicate RCSLT endorsement. RCSLT considers that managers are best placed to advise their staff on the most appropriate formal training/education opportunities.

Where possible the Framework has been broadly mapped to the NHS KSF dimensions but you will need to know which level you are at with the KSF. For each type of CPD opportunity we have also indicated core skills, a key focus or competencies that we feel are relevant to the category e.g. critical analysis, influencing, awareness of equality and diversity.

For all within the SLT workforce this Framework can be used to look at CPD that you might do both in the short-term in your current role and in the long-term as part of planning your career.

Outcomes have also been listed for every stage of this framework. We have tried to relate these to practical pieces of work or to career 'landmarks' that you might be focussing on. These are illustrative rather than prescriptive and we hope that they will provide useful reference points and support you with your career choices and development.

Why has RCSLT developed the CPD framework?

The SLT workforce has a legitimate expectation to be able to access the information they need to plan their careers; to access effective careers guidance, and to form realistic expectations about their own career opportunities.

Feedback from RCSLT members was that you were looking for a well-defined career framework that:

- was flexible with your changing roles and settings
- could help you to develop new capabilities in response to the changing health, education and social care environments

You told us that you wanted to be better positioned for success in leadership, management, research and educational roles and as the professional body we wanted to support you to do that.

Is the CPD framework mandatory?

No, it isn't. However, CPD is already mandatory for SLTs and RCSLT has the aspiration that over time this framework will be incorporated as an integral part of workforce planning and development. The framework is also intended to be used alongside the RCSLT policy statement on education and training for support workers and assistants where a recommendation for a number of CPD hours has been set out.

It has been designed with input from SLTs and assistants to be a useful and supportive resource for everyone who is part of the SLT workforce.

How does the CPD framework link with the CPD diary?

We have used the same categories in the CPD framework as we have in the CPD diary, i.e. work based learning, formal education, self-directed learning, which were set by HPC. The only difference is that we have used the heading 'SIGs and Peers' in the CPD framework which would fit the CPD type 'Professional Activity'.

The HPC types of CPD that we have mirrored in this framework and the CPD diary are:

- Work-based learning
- Professional Activity
- Formal Education
- Self-directed learning

We have also listed the KSF dimensions for each CPD activity and we hope that this is helpful to those RCSLT members who use KSF.

How do I use the framework, how can it help me?

Cost effective CPD opportunities

You might want to do a piece of CPD around equality and diversity but your employer may not have the resources to pay for a course. The CPD framework will signpost you to possible CPD opportunities and activities you could undertake and reflect on to demonstrate how your CPD has sough to enhance service delivery and to be of benefit to service users.

Strategic Career Planning

You might be looking to move from an operational role to a more strategic one. The framework will show you how to access strategic thinking and influencing skills right now in your daily working life. If you're planning your CPD in advance and know that there's a course or a conference you would like to attend you could seek sources of funding from your employer or other organisations in advance. It's important to be strategic with CPD opportunities which is likely to include:

- creating your own development plan
- taking the initiative
- researching courses, literature and other resources
- contributing your time to CPD development (eg. Writing papers, preparing audits etc),
- working collaboratively with colleagues/users to ensure that your development matches the needs of the service and that you always seek to be of benefit to service users

Maintaining Knowledge and Skills

You might be on a non-clinical secondment or on maternity leave but still want to keep your knowledge and skills up to date. The framework will give you many suggestions for self-directed learning you can undertake.

Applying for new jobs

Whether you're completing an application form or being interviewed, prospective employers will ask you demonstrate how you meet the job description and person

specification. This framework will allow you to relate your work experience and expertise to many of the skills and attributes that employers will be seeking.

Using what you're already doing to count as CPD

Potentially, if you have undertaken an activity or work, reflected on and learnt from it, in line with the HPC and RCSLT Standards, then it should count as CPD. As members of RCSLT you have access to a range of resources and as you will see from the different sections of the framework there are significant work-based learning opportunities.

What should I do if I have done a piece of CPD that isn't covered in the framework?

If the CPD activity has enabled you to demonstrate that you have endeavoured to enhance service delivery or be of benefit to service users then it 'counts' as CPD. We would be really grateful if you could contact the Professional Development team at RCSLT (cpd@rcslt.org) to suggest that the activity could be included in the framework. It would be very helpful if you could also indicate which broad heading you think this CPD best fits with (e.g. leadership, ethical practice, research) and to which KSF dimensions it could be linked. This isn't a finite list we're sure you will be doing much more that counts as CPD.
If you think that there are errors or omissions in respect of the KSF we're happy for you to let us know.

Some of the activities suggested for my level seem quite challenging. How did RCSLT choose the CPD categories and where they fitted in?

This framework has been put together by the RCSLT professional development team together with a working group of RCSLT members. The working group included:

- NQP
- Assistants
- Consultant SLT
- SLT Managers from across the UK
- Academic SLTs
- SLTs working in independent practice

The main categories were agreed by the RCSLT Professional Development and Standards Board and the RCSLT Management Board provided significant input. We hope that people will find the CPD framework a challenging, but ultimately supportive, resource so that the SLT workforce can continue to meet the needs of service users.

How is the framework relevant to support workers and assistants?

Support workers and assistants have been involved at every stage of the development of this document and RCSLT recognises the significant contribution that they make to the overall achievements of the SLT workforce.

This Framework should be used in conjunction with the CPD guidance set out in the RCSLT policy statement on Education and Training for Support Workers and Assistants. Within this policy statement RCSLT recommended that support workers and assistants aim to do between 24 and 30 hours of CPD per year. This framework is a resource that will help you to achieve this.
http://www.rcslt.org/resources/publications/Assistant_edu_final_to_Council.doc

Within this CPD Framework assistant practitioners refers to people who have successfully completed a Foundation Degree.

I work at a band 3 and have done some of the CPD activities you have listed for a band 4 or 5, what does that mean?

There can be significant differences between employers about the expectations they have for Assistants/Support Workers. We acknowledge that there may be some overlap in activities and have tried to reflect the situation for the majority of members without being too prescriptive. We hope that when choosing CPD activities assistants and support workers will receive appropriate guidance from their managers.

I'm newly qualified do I have to do the NQP framework and use the CPD framework?

The NQP framework is a compulsory part of your RCSLT membership. The CPD framework is a resource that we hope will support you to complete the NQP framework because it will give you and your manager ideas for the types of activity you could do to demonstrate that you have completed the NQP framework.

Once you have completed the NQP framework you will need to do CPD regularly and you may still be in a newly qualified/band 5 role.

For many of the activities we have tried to show how there is a development of knowledge and skills throughout a career path. As a NQP you may have the ambition to move into a research environment or a leadership role, using the framework you will be able to see and plan for the type of CPD you might do to achieve this.

If I have done everything listed for the band above me, am I entitled to a promotion?

The RCSLT is not a trade union or an employment law specialist and therefore cannot advise on terms and conditions of employment. You will need to discuss your career development opportunities with your line manager. It is important to remember that salaries relate to work roles not to individuals' achievements. Managers have to plan their services and staffing levels according to the needs of the population and within their allocated budget and therefore are unlikely to have the flexibility to re-grade posts.

Can I discuss this framework with my employer? Can I use this framework to guide my staff?

Yes, we hope that employers and employees will use the framework as part of their regular meetings and appraisals so they work together to plan CPD opportunities.

Where can I find more support with CPD?

All the RCSLT resources that have been designed to support you with CPD are on the web pages: **http://www.rcslt.org/cpd/resources**. There is also a link to the statement on protected time for CPD, signed up to by the RCSLT, along with other professional bodies. **http://www.rcslt.org/cpd/jointstatementonprotectedtime.pdf**

Feedback from RCSLT members, to date, on the CPD Framework

1. Introduction excellent loved the bit on why developed framework, loved the examples of how to use etc. really clear and concise
2. This seems very comprehensive. It is an essential document and will be very important to employers especially non NHS who really don't know about AFC and the different bandings. In my school we employ a assistants, a newly qualified therapist and two experienced therapists. We are not teachers and it is important that the school is aware of our CPD needs.
3. The framework is useful. I like the larger number of sections, it helps when struggling to decide where to put activity. I would prefer the KSF to be kept in.
4. It will be very useful to members and in particular as a basis for structuring the thinking of all members and of managers and their staff in supervision and appraisal situations.
5. I think that this information will be immensely helpful to staff and managers alike. I believe that SLTs need as much support as possible with translation of actions into KSF profiles. I don't think we can ever assume that anyone has memorised the manual!!
6. I think the document is useful and well laid out. It would support the appraisal process well.

RCSLT CPD Framework – **Ethical practice** *including cultural issues, client autonomy, equality & diversity, access*					
Equality & Diversity (ED) Client Autonomy (CA) KSF	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Respecting chosen method of communication (CA) Demonstrating awareness of ethical considerations in practice and making culturally appropriate resources (ED) Participating in supporting people to use AAC (CA) Effective joint working, supporting SLT, e.g. during visit or group (ED) Monitoring and amending service information for the public (ED, CA) Core 1 C HWB 1 Core 3 HSS HWB 4 Core 6 ED HWB 9	Undertaking equality and diversity training (ED) Basic Mental Capacity Act Training or awareness of MCA (ED, CA) Protection of Vulnerable Adults / Child Protection (ED) Confidentiality (ED) Safeguarding (ED) Core 3 HSS Core 6 ED	Discussion on supporting staff/carers to enable choice and diversity by using and respecting chosen methods of communication (CA, ED) Participate in discussion with colleagues of ethical considerations (ED) Clinical Supervision (ED) Discussion with E&D officer in organisation (ED) Core 1 C Core 2 PP Core 6 ED	Reading and reflecting on local policies/codes of ethical practice (ED) Relevant E-learning/ Research (ED, CA) Core 2 PP Core 3 HSS Core 6 ED	Participate in ensuring and supporting the equality and diversity agenda within services.
Assistant Practitioners (Bands 4-5)	Supporting people to use AAC (CA) Ensuring resources are culturally appropriate (ED) Core 1 C HWB 2 Core 2 PP HWB 4 Core 6 ED HWB 9 G1 LD	AAC training (CA) Protection of Vulnerable Adults /Child Protection (ED) Confidentiality (ED, CA) Safeguarding (ED) Core 1 C Core 2 PP	Discuss how to support people to use different communication systems in different settings (CA) Mentoring new support workers (ED) Case discussion (ED, CA) Core 1 C Core 2 PP Core 6 ED	Read and reflect on disability discrimination act (ED, CA) Relevant E-learning/Research (ED, CA) Core 2 PP IK 3	

RCSLT CPD Framework – **Ethical practice** *including cultural issues, client autonomy, equality & diversity, access*					
Equality & Diversity (ED) Client Autonomy (CA) KSF	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
NQPs (if not within NHS consider 1-2 years' work experience)	Running SLT groups that meet the needs of different client groups and communities (ED) Supporting service user groups (ED, CA) Ensuring carers and families are actively engaged with service developments (ED, CA) Ensuring clients have right to consent or refuse treatment. (CA) Adapting resources where appropriate to be culturally appropriate (ED) Reviewing own work area against access criteria (CA) Understanding the ethics of decision making for dysphagia (CA) Core 3 HSS Core 6 ED HWB 1 HWB 2 HWB 3 HWB 4 HWB 5 HWB 6 HWB 7 HWB 10 G1 LD	Record keeping (ED) Data protection training (ED) Training around confidentiality and anonymity of service users (ED, CA) Training in assessing bilingual service users (ED, CA) Freedom of information act (ED) Protection of Vulnerable Adults Mental Capacity Act (or in Scotland Adults with Incapacity Act) Informed consent Child Protection (ED) IK 2 Core 2 PP HWB 3	Discussion with colleagues about evidence based/informed practice (ED) Clinical Supervision (ED) NQP SIGs (ED, CA) Peer/Buddy Support (ED) Core 2 PP Core 5 Q	Reading and reflecting on relevant sections of CQ3 (ED, CA) Reading and reflecting on HPC standards of proficiency and conduct ethics and performance (ED) Promoting SLT services community events (ED, CA) Reading and reflecting on current literature in ethics and SLT e.g. dysphagia (ED) Reading and reflecting on all RCSLT invasive procedures position papers (ED) Core 2 PP IK 3	Ensure that client autonomy and the needs of service users are integral to practice and inline with the evidence base
Band 6 (if not within NHS consider 3-5 years' work	Designing service user feedback mechanisms that are relevant to the client groups and the local need (CA)	Mental Capacity Act or in Scotland Adults with Incapacity Act (ED, CA) Informed consent (CA)	Attendance at Medico-legal SIG (ED) Developing service with MD/integrated	Reading and reflecting on RCSLT Policy statement on evolving roles (ED)	Promote and develop ethical practice as part of a team

RCSLT CPD Framework – **Ethical practice** *including cultural issues, client autonomy, equality & diversity, access*					
Equality & Diversity (ED) Client Autonomy (CA) KSF	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
experience)	Evaluating clients' accessibility to service (CA) Shadowing colleague to learn about writing SEND reports (ED) Developing service provision with bi-lingual co-workers (ED) Identifying risks and alerting manager/supervisor (ED) IK 2 IK 3 Core 3 HSS Core 4 SI Core 5 Q Core 6 ED	Ongoing POVA / Child protection (ED) Core 1 C Core 2 PP	teams (ED, CA) Core 1 C Core 2 PP Core 4 SI Core 5 Q HWB 5	Reading and reflecting on local ethical research policy/standards (ED) Reading and reflecting on RCSLT SEND Guidelines (ED) Reading and reflecting on all relevant RCSLT position papers and policy statements (ED) Core 1 C Core 2 PP G2 DI	
Band 7 (if not within NHS consider 6-10 years' work experience)	Defining and implementing action plan as part of RCSLT Q-SET (ED, CA) Implementing national standards on ethics and ethical practice at local level (ED) Carrying out regular risk assessments for staff, service users, students and report any findings to team and senior staff (ED, CA) Ensuring service users'	Recruitment and Selection training (ED) Expert witness training (ED, CA) Intermediary training (ED, CA) Research ethics training (ED) Core 1 C Core 2 PP G6 PM G7 CC	Being RCSLT Clinical Adviser(ED) Giving seminars/ lectures on ethical practice to SLT students (ED) Undertaking expert witness work (ED, CA) Inputting to local clinical governance initiatives (ED) G1 LD G5 SPM Core 1 C Core 2PP	Reading and reflecting on the extent to which legislation is applied in the culture and environment of clinical speciality. (ED) Reading and reflecting on journal articles/ national policy and standards relating to ethical practice/clinical ethics (ED) Reading and evaluating research/ new initiatives in this area (ED, CA)	Promote positive value based services for people with a communication disability Promote and develop ethical practice in own work and in that of others and that it conforms to legislation and guidance

RCSLT CPD Framework – **Ethical practice** *including cultural issues, client autonomy, equality & diversity, access*					
Equality & Diversity (ED) Client Autonomy (CA) KSF	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	focus has been taken into account for all activities and service development (CA, ED) Core 2 PP Core 3 HSS Core 4 SI Core 5 Q Core 6 ED			Identifying relevant new policies/research and ensuring colleagues are informed (ED) Core 1 C Core 2 PP G2 DI	
Bands 8 and 9 (if not within NHS consider 10+ years' work experience)	Developing codes of ethical practice for employer/professional body/regulator (ED) Developing an extended role in line with local and professional body protocols (ED, CA) Monitoring and evaluating the local complaints process and providing feedback to service users (CA) Ensuring transparency and accessibility of local policies and procedures for service users (CA, ED) Reviewing and evaluating AAC provision within the service (CA) Reviewing and evaluating diversity policies and service inclusion of all population groups (CA)	Attending and/or presenting at conference on clinical ethics (ED) Attendance at conferences/courses focused on ethical practice/cultural issues/ equality and diversity (ED) Contribute to teaching in this field (ED) Ethics as part of management/leadership training (ED) Core 1 C Core 2 PP Core 6 ED G1 LD G6 PM G7 CC	Contributing to RCSLT Communicating Quality Updates and other professional standards (ED) Member of local disciplinary/fitness to practice panel (ED) HPC Fitness to Practice assessor (ED) Designing and developing ethical research projects (ED) Contributing to the development of relevant NPSA guidelines (ED, CA) Mentor/mentee (ED) Core 2 PP Core 3 HSS Core 4 SI Core 5 Q G7 CC	Reading & reflecting on legislation, interpreting how it may impact on local service delivery (CA) Seeking out new policy initiatives and applying to own team (ED) Interpreting new policy and application to service (ED) Writing papers for organisational boards (ED) Core 1 C Core 2 PP IK3 G5 SPM	Influence the ethics agenda Ensure teams are informed and management alerted to implications of policy and that service interprets legislation to inform individuals' rights and responsibilities

RCSLT CPD Framework – **Ethical practice** *including cultural issues, client autonomy, equality & diversity, access*					
Equality & Diversity (ED) Client Autonomy (CA) KSF	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Conducting Impact Assessments on E&D for organisation (ED) Taking action in response to risk reported by junior staff (ED) Core 1C Core 4 SI IK3 G5 SPM G6 PM G7 CC				

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Attendance at team building activities (I) Facilitating group activities with service users (I) Informal coaching or feedback to other professionals/carers (I) Develop resources for clients / events (S) Influencing skills/strategic coaching from others (S, I) Core 1 C Core 2 PP HWB 9	Attending Makaton training (I) Training in working with families (I) Assertiveness training or negotiation skills training (I) Presentation skills training (I) Presenting details of work/service/role to students/families/other stakeholders (I) Training in delivering specific parent/carer programmes (I) Core 1 C Core 2 PP G1 LD	Shadow others to learn and reflect on how collaborative problem solving supports service delivery (I) Attending a SIG sharing knowledge with peers back in the service. (I) Attending Staff meetings (I) Core 2 PP Core 5 Q	Being aware of local policies and strategies and how these relate to own work role (S) Internet research/E-Learning Communicating with Assistant reps on RCSLT Boards to understand the strategic roles they have and to input to the strategic work being undertaken in relation to assistants (S,I) Core 2 PP IK3	To be part of a team work with other staff, other clinicians, parents and carers to support people with SLCN and to build effective working relationships with other professionals e.g. doctors, teachers, other AHPs
Assistant Practitioners (Bands 4-5)	Inputting to strategies and strategic plans (S) Learning and developing leadership/influencing skills/ strategic thinking through coaching from others (I, S) Mentoring new support workers (I)	Providing training to others e.g. at Inset or for Makaton (I) Information Management/Computer Skills Training e.g. databases, electronic patient records, ECDL (S)	Involvement in running a SIG (I) Being a school governor (S) Contributing to the National SIG for Assistants (S, I)	Internet research / e-learning / reading on leadership styles (S) Communicating with Assistant reps on RCSLT Boards to understand the strategic roles they	

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Participating in induction for new staff and students (I) Providing formal coaching to other professionals/ parents/carers to support service users (I) 4-5 Contribute to the planning and support for the departmental event/showcase/ achievements bulletin for commissioners and other key stakeholders (I) Supporting/supervising students and NQPs (I) Input to service training on databases and electronic records (S) Core 1 C Core 2 PP IK1 G1 LD G6 PM	Goal setting outcomes(S) Financial / purchasing training (S) G3 LD G3 PC G4 FM	Taking on responsibilities within department such as Manual Handling Rep (I, S) G5 SPM Core 1 C Core 2PP Core 3 HSS	have and to input to the strategic work being undertaken in relation to assistants (S,I) Core 1 C Core 2 PP IK3	
NQPs (if not within NHS consider 1-2 years' work experience)	Leadership/influencing skills/ strategic thinking coaching from others (I, S) Providing coaching to other professionals/	Training in working with families (I) Time management course (S) Presentation skills	Review collaborative problem solving skills learnt at university and apply to working environment (I, S)	Reading and reflecting on professional and regulatory body strategies (S) Reading and	Understanding the differences between strategic and operational work Awareness of Caldicott, clinical coding, freedom of

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	parents/carers to support service users (I) Being part of SLT service working groups (I) Considering / inputting to how the service is delivered (S, I) Putting principles in to practice and training eg databases, electronic records (S) Building professional networks and relationships (I) Working appropriately with support workers and associate practitioners e.g. developing therapy programmes etc (I) Using data/evidence to track changes in workload (S) G1 LD G6 PM G8 PRM Core 1 C Core 2 PP Core 4 SI Core 5 Q	training (I) (4-5) Negotiation/Advanced Communication skills training (I) Information Management Training e.g. databases, electronic patient records (S) Outcome setting (S) Financial awareness (S) Training around local and national policies (S) Participating in presentations on SLT to school age students/local career events (I) Core 1 C Core 2 PP G4 FM	Communicating with NQP reps on RCSLT Boards to understand the strategic roles they have and to input to the strategic work being undertaken in relation to NQPs (S, I) Responding to RCSLT Consultations (S,I) Participate in audits related to professional activities such as clinical supervision (S) Core 1 C Core 2 PP Core 4 SI	reflecting on major national policy documents and how they relate to service delivery (S) Internet research on leadership styles and learning styles (S) Build professional network using on-line resources (I) Reflective diary workshop on RCSLT website Core 1 C Core 2 PP IK3	information act, data protection security of information
Band 6 (if not within NHS consider 3-5 years' work	Putting principles in to practice and training e.g. databases, electronic records (S)	Management training course (S) Undertaking	Undertaking a governance role as a trustee with a charity or school (S)	Reading and reflecting on national policy documents and	Understand the differences between management and leadership

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
experience)	Induction for new staff (I) Inputting to local clinical governance initiatives (I) Supervising assistants (I) Supervising students on placement (I) Providing coaching sessions (I) Representing department on internal committees (I) Identify own learning goals for PDPs (S) Core 1 C Core 2 PP Core 3 HSS Core 4 SI Core 5 Q G6 PM	coaching/mentoring training course (I) Influencing and Negotiating Course (I) Clinical Supervision (S, I) Placement educator training (S) Leadership at the point of care (S, I) Core 1 C Core 2 PP G1 LD G6 PM	Attending regional networking opportunities (I) Being a member of an RCSLT Board or working group (S) Union representative (I) Supervising students (I) Core 1 C Core 2 PP G6 PM	explaining their relevance to other stakeholders (I, S) Developing skills in developing own informal and formal professional networks. (I) Core 1 C Core 2 PP	Plan own route and milestones for achieving a leadership role Be an advocate for profession
Band 7 (if not within NHS consider 6-10 years' work experience)	Appraising reflective writing (I) Assessing PDPs (S and I) Being an expert witness (S and I) Completion of RCSLT Q-SET (S) Implementing employer's policies (I, S) Representing employer on internal and external	Being an assessor/examiner for NVQs, SVQs, NOS (S, I) Leadership training (I) Organising accredited/registered CPD courses (S, I) Organising and presenting in-service training (S, I)	Being an RCSLT advisor and within that role providing guidance and leadership to relevant SIG (I, S) Running SIGs/journal clubs (I) Developing professional body guidelines or	Reading and reflecting on relevant national policy documents and ensuring that these are embedded in the working culture and that these inform local policy and service development (I, S) Considering national policy documents	Use strategic and influencing skills beyond the departmental environment Identify how national priorities impact on local priorities for commissioners and employers Responsibility for team, budget, and human resources

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	committees (I, S) Leading a peer review exercise (I) Managing project team (I) Providing coaching sessions (I) Analysing and identifying local decision makers' priorities (S, I) Organise department showcase/event/ achievements bulletin for commissioners/ key stakeholders that are explicitly linked to their agenda (I) Using influencing and negotiating skills for the benefit of the service (I, S) Managing operational procedures for absence management (S, I) Core 1 C Core 2 PP Core 4 SI Core 5 Q G6 PM	Advanced Influencing and Negotiating Course (I) Personal development plans Project Management (S) Basic Human Resources (S, I) Leading Empowered Organisation LEO (S, I) Health Professions Officers' conferences (I, S) Core 1 C Core 2 PP G6 PM	position papers (S, I) Actively participating in regional and national networks (I) Participate in routine staff Management and recruitment (S) AHP leadership challenges (S, I) Personal Development Plans (S) Core 1 C Core 2 PP Core 4 SI Core 5 Q G6 PM	from an influencing and leadership perspective (I) Considering relevant national policy documents in relation to service redesign (S) Core 1 C Core 2 PP Core 4 SI Core 5 Q G7 CC	
Bands 8 and 9 (if not within NHS consider 10+ years' work experience)	Participating in policy development events professional, government, national and regional (S, I)	Financial planning/ budget management training (S) Advanced HR training	Developing an evolving role (S, I) Member of practice based	Reading and summarising key national policy documents for team, parents and	Influencing partnerships (education, service, research, across acute and community services)

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Preparing a business case for service provision (S, I) Chair Committee (S, I) Implementation of Q-SET Action Plan (S) Implementing and writing employer's policies (S, I) Leading a team (S, I) Leading a clinical audit / service review and evaluation (S, I) Meeting with service commissioners (S, I) Supervising and signing off NQP/ preceptorship documents (I) Strategic stakeholder meetings (3rd sector, LA, HEIs, Schools) (S, I) Providing coaching sessions (I) Establish and maintain communication channels with commissioners et al (I) Influencing information governance process through attendance at relevant groups and forums and influencing	(e.g. interview and selection, undertaking appraisals) (S) Media training (S, I) Teaching on placement educators course (S) Root cause analysis training (S) Bursaries training (S) Project management Leadership programmes (S, I) Core 1 C Core 2 PP G4 FM G7 SPM G6 PM G7 CC	commissioning group (S, I) Being a member of RCSLT Council (S, I) Wider AHP remit and influencing SHA level (I) Core 1 C Core 2 PP Core 4 SI Core 5 Q G4 FM G6 PM G7 CC	commissioners (I, S) Core 1 C Core 2 PP Core 4 SI Core 5 Q G7 CC	Horizon scan and identify work areas from emerging national themes Set the direction of SLT services and drive through change and development

RCSLT CPD Framework – Human and Financial Leadership and Resource Management					
Influencing (I) Strategic Thinking (S) KSF	**Work based activity**	**Formal Education e.g. face-to-face or online courses, training & conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	data standards (I) Awareness of information governance and its impact at a local level (S) Caseload analysis (waiting lists, caseload size and caseload complexity) to lead service development (S) Undertake major service redesign involving stakeholders and best evidence (S, I) Creating service plans that inform all service development (S) Core 1 C Core 2 PP Core 4 SI Core 5 Q G6 PM G7 CC				

RCSLT CPD Framework - Research awareness, activity and engagement					
CA = Critical analysis DA = Data Analysis **KSF**	**Work based activity**	**Formal education e.g. courses, training and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes: Building research capacity within the SLT profession**
Support Workers (Bands 2–3)	Reflect and evaluate case notes and discuss at supervision or team meetings Peer observation/ shadowing and reflection Undertaking surveys or audits relevant to work e.g. staff and service user surveys CA DA Core 2 PP Core 5 Q HWB all	NVQ / SVQ Courses to be targeted for personal development needs and to build skills base in order to implement what has been learned with clients CA Core 2 PP	Attend SIGs Engage with peer networks Link with professional body activities and feedback to appropriate members of team CA Core 2 PP	Reading relevant books/clinical handbooks with support and guidance from manager to critically appraise CA Core 2 PP IK 3 Submitting applications for RCSLT minor grants or for employer funding for courses	Support department / team to design and develop posters
Assistant Practitioners (Bands 4-5)		HNC Foundation degree As above plus the requirement for learning to be cascaded to team CA Core 2 PP			Design posters for presentation as part of coursework Participate in SLT research projects
NQPs (if not within NHS consider 1-2 years' work experience)	Attend journal club Participate in clinical audit Contribute to departmental R&D activities CA DA Core 2 PP Updating service users on research findings and initiatives Feedback to team on SIGs/courses etc. Prepare project bids for internal developments	Courses to be targeted for professional development needs with appraisal and evaluation of how course relates to practice and service Electronic learning on critical appraisal CA Core 2 PP	A contributing member of a SIG Access Research and Development Support Units (RDSU) to become familiar with new information and resources CA Core 2 PP Participate in locally driven research	Hypothesis testing in individual case studies Revisiting statistics skills from pre-reg training. Updating critical analysis skills. Search, read, appraise and evaluate appropriate literature/research presented at SIGs CA DA Core 2 PP, IK 3 Submitting applications for RCSLT minor grants	Submit posters to conferences

Research awareness, activity and engagement					
CA= critical analysis DA = data analysis KSF	**Work based activity**	**Formal education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes: Building research capacity within the SLT profession**
Band 6 (if not within NHS consider 3-5 years' work experience)	Placement educators set up system to work with NQPs, students and support workers to relate the evidence base to practice Contribute to departmental R&D activities CA Core 2 PP G6 PM G1 LD	As for band 5 plus cascading knowledge to department in form of internal training Attendance at relevant conferences CA Core 2 PP	Presenting at SIGs, departmental training and journal clubs CA DA G1 LD	Regular reading of primary research and discussion of pilot options at supervision or teams meetings CA Core 2 PP IK 3 Researching funding opportunities and supporting colleagues with applications CA	Submit posters to conferences Submit papers to conferences as part of SLT team Submit funding bids
Band 7 (if not within NHS consider 6-10 years' work experience)	Leading and supporting other staff with research activity Writing up research to **advise** management team re care pathways **Prepare summary for presentation to Boards** Directing clinical care R&D activities to constitute significant part of job requirements CA G6 PM Core 2 PP Core 5 Q	Undertaking MSc or post-graduate qualification assimilation of professional courses and to demonstrate knowledge of evidence in clinical area Active participation at conferences as delegate and to run workshops/symposia CA DA Core 2 PP G1 LD IK 2 IK 3 G2 DI	Set up SIG or journal club Every RCSLT adviser must be linked to a SIG Every SIG maintain regular contact with the advisers from their clinical area SIGs to read and appraise relevant papers annually CA DA Core 2PP G1 LD G5 SPM	Design local pilot for research project e.g. clinical audit Read a minimum of 3 research papers per year, critically appraise and reflect on as part of CPD Respond to consultations on position papers when required CA DA Core 2PP IK3 Core 4 SI Core 5 Q Engaging with MDTs to submit funding applications	Submit papers to conferences based on research in specialist area

Research awareness, activity and engagement					
CA = Critical analysis DA= data analysis KSF	**Work based activity**	**Formal education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes: Building research capacity within the SLT profession**
Bands 8 & 9 (if not within NHS consider 10+ years' work experience)	As for band 7 plus For clinical band 8 undertaking research studies in specialist clinical area Bidding for research funding Considering impact of research on practice. Making links between research and national strategic initiatives. For managerial band 8 CQ3 updates, policy work, clinical guidelines updates Co-ordinating or initiating local or national research in specialist field CA DA G6 PM Core 2 PP Core 5 Q	As for band 7 plus MRES, PhD, EdD CA DA G1 LD IK 2 IK 3 G2 DI	Strategic working may include professional representation at NICE/DH/DCSF/NPSA consultations or steering groups, position papers, direct engagement with professional body initiatives CA Core 5 Q Core 4 SD	Writing clinical handbooks, part of position paper working groups, engaged with development or consultation on policy/political document CA DA Core 4 SD Core 5 Q	Submit papers to conferences Accessing funding for research

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Identify and report significant incident (CR) Reflect on learning (CR) Evaluate own sessions (CR) Local induction (P) Shadowing and learning about the roles of others (P) Clinical learning groups (CR) Design/adapt resources and equipment to meet specific requirements of individual client (P) Core 2 PP Core 3 HSS Core 5 Q HWB 1 HWB 9	Communication Observation (CR) Commercially available programmes that are off the shelf (P, CR) NVQ/SVQ (CR, P) Boardmaker Makaton Derbyshire Eklan - Level 3 (P) Mandatory training eg. Equality / Diversity (P) Clinical Governance, Quality (CR, P) Infection control Mandatory training (H&S / Equality & diversity) (CR, P) Caseload specific courses (P) Core 1 C Core 2 PP	SIG Conference (CR, P) Local support Group (P) Peer supervision (CR, P) Clinical Supervision Case-note review and discussion and application to own caseload (CR, P) Clinical supervision groups (CR, P) Member of Uni / multi professional groups (CR, P) Core 1 C Core 2 PP	Shadow therapists (CR, P) E-learning courses (P) Preparation for supervision (CR, P) Case-note review and discussion and application to own caseload (CR, P) Completing CPD log (CR) Reflect on learning to implement changes in work based activities (CR, P) Core 1 C	Ensure safe practice and good outcomes for service users
Assistant Practitioners (Bands 4-5)	Inputting to planning and formulation of service delivery policies through staff meetings and working	BTEC/NVQ3 (P) Caseload specific courses/conferences (P)	Help Support Workers with changes to plan case discussion (CR, P) Sharing ideas (CR, P)	As above Relevant Reading (CR, P)	As above Adhere to local, departmental, organisational and

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
	groups (P) Identify and report significant event, reflect on learning and suggest solutions (CR) Designing equipment to meet specific requirements (P) Reflective practice / clinical supervision (CR, P) Local induction (P) Shadowing (CR) To be able to carry out specific assessment within remit (CR) Participate in clinical learning groups (CR) Core 4 SI Core 5 Q HWB 1 HWB 2 HWB 9	Teacher talk Boardmaker Makaton Signalong NVQ/SVQ Assistant support group (CR) Assistants conference (CR, P) Level 4 qualification (P, CR) Core 1 C Core 2 PP IK 2	SIGs/ Local support group (P) Provide Mentorship & advice for Band 2/3 (CR, P) Core 1 C Core 2 PP G1 LD G6 PM	E-learning (relevant courses) CPD log (CR) Core 1 C Core 2 PP	professional policies and standards, within remit Recognise problems with above and able to suggest solutions.
NQPs (if not within NHS consider 1-2 years' work experience)	Significant event analysis (CR) Independent working	Learning roles of other profs in team. -Roles -Benefits	Attending relevant clinical SIG meetings (CR, P)	Read and reflect on local, departmental, organisational policies, and RCSLT code of	Complete RCSLT NQP framework Critical analysis of

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
	with 'straight forward' cases (CR) Work with more complex patients accessing supervision (CR) Flying Start (Scotland) (CR) RCSLT NQP Framework (CR) Local induction Shadowing other AHPs and more senior SLTs (CR) Present case to mentor as part of RCSLT competencies (CR, P) Individual case-work – description of diagnosis with mentor in respect of RCSLT competencies (CR) Preparing clinical reports (CR, P) Core 5 Q HWB 1, 2, 3, 4, 5, 6, 7, 9	-Communication in relation to their needs (CR, P) Clinical courses eg dysphagia – post basic (CR, P) In-house training events / multi agency events, leadership events Duty of care Clinical Governance / Quality Employing organisation's mandatory training (P) Learning clinical reasoning and decision making relevant to client group (CR) Core 1 C Core 2 PP	Mentorship/Shadowing specific to job (CR) Clinical supervision (CR, P) Requesting 2nd opinion from colleagues/joint consultation (CR) Peer supervision (CR) Participation in audits (CR, P) Core 1 C Core 2 PP Core 4 SI Core 5 Q	ethics and professional conduct (CR, P) Critical appraisal of articles (CR) Identify research questions (CR, P) E-learning Reflections on clinical supervision (CR) Maintaining CPD log/ Keeping reflective diary/recording reflective learning in NQP framework (CR, P) Core 2 PP	reading Progression through KSF Foundation gateway Safe practice ensured and quality service delivered

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
Band 6 (if not within NHS consider 3-5 years' work experience)	Identifying areas for improvement and putting forward solutions (CR, P) Begin role as clinical educator (CR, P) Shadowing (CR) Mentorship and advice to earlier bands on casework (CR, P) Personal Development Plans (CR, P) Clinical supervision (CR, P) Lead on items / issues eg. journal club, audits (CR, P) Contribute to service redesign and 2nd opinions (P, CR) Have the opportunity to work with more complex cases on a regular basis, with supervision (CR, P) Core 2 PP G5 SPM Core 4 SI G6 PM Core 5 Q G7 CC G1 LD HWB 1-7	Clinical educator training (CR) Mandatory training (P) Relevant In-house training (P) Leadership events (P) Identified post-grad study (P) Attending courses & conferences relevant to clinical area eg. post basic dysphagia PETAL (CR, P) Core 1 C Core 2 PP	Presentations and discussions at SIGs and at team clinical hours (CR) Clinical supervision (CR, P) Member of SIG (P) Discussion about client group specific / specialism (CR, P) Peer review (CR) Teaching clinical reasoning and decision making to peers (CR) Core 1 C Core 2 PP Core 5 Q G1 LD	Read and analyse relevant articles around clinical area in order to present on specialism and evidence base (CR) Presenting at journal clubs (CR) CPD log-reflection (CR) Evaluative audit of practice and more specific methodology eg. Audit & making changes to service delivery (P) Evidence base – ready collating (CR, P) Core 2 PP IK2	Independent working accessing supervision as required. Ensure effective services and Best outcomes for users

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
Band 7 (if not within NHS consider 6-10 years' work experience)	Synthesizing approaches to clinical practice (CR, P) Lead on service change (P) Undertaking complex caseloads (CR, P) Prepare and deliver training to staff (P) Prepare and deliver training day for team (CR, P) Deliver management training (P) Leading on and provide specialist. advice on own discipline to SLTs and other professions (CR, P) Leading on clinical reasoning and decision making for specific client group (CR) Core 4 SI Core 5 Q G1 LD G6 PM G7 CC HWB 1-7, 9	Relevant specialist courses or conferences (CR, P) Masters degree (or equivalent leadership qualification) (CR, P) Leadership events (P) Core 1 C Core 2 PP G1 LD G2 DI IK2 IK3	Identifying areas for research CR, P) Peer review research (CR. P Act as clinical supervisor (CR) SIGs – relevant to speciality (CR, P) Reflect on service-wide issue related to speciality (CR) Presenting at SIGs and possibly leading (CR, P) Data analysis for team use (CR, P) IK2 IK3	Regularly read articles and undertake literature searches CPD log-critical reflection Audit research Reflect on evidence based practice and make recommendations about service enhancements Leading research, accessing evidence-base to make service-wide recommendations Reading journals, e-based learning Core 1 C Core 2 PP Core 4 SI IK2	Ensure robust clinical skills and judgements Lead, supporting and develop others

RCSLT CPD Framework - Clinical Effectiveness, Reasoning and Analysis – *critical analysis & interpretation, differential diagnosis*					
Critical Reflection on Practice (CR) Planning (P) to include evidence, experience and service user preference **KSF**	**Work based activity**	**Formal Education e.g. courses, training and conferences**	**Professional Activity with SIGs or peers**	**Self-directed learning**	**Outcomes**
Bands 8 and 9 (if not within NHS consider 10+ years' work experience)	Undertaking leadership roles and responsibilities (P) Ensure application of national strategy and policy to whole services and share with other organisations (P) Data collection and analysis at all levels (CR, P) Defining clinical and managerial overview for an area / case group (P) Core 4 SI Core 5 Q G1 LD G2 DI G5 SPM G6 PM G7 CC	Leadership training (P) Highly Specialist clinical courses and conferences (CR, P) Management/leadership courses (P) National conferences (P) Masters or PhD level qualification Core 1 C Core 2 PP G1 LD G2 DI IK2 IK3	Professional lead/ Managers group (P) Undertaking Clinical Supervision (CR, P) Leading SIGs as appropriate (CR, P) Coaching others (CR, P) PECs (or equivalent) provider, Boards etc IK2 IK3	CPD log-reflection (CR) Sourcing and using National Documents to influence and evidence service delivery (CR, P) Reading E-learning Reflection Core 1 C Core 2 PP Core 4 SI IK2	Leader and clinical expertise Viewed as leader and source of experience

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Analysing significant events /critical incidents (SD) Shadowing and mentoring peers and clinicians (SD) Clinical Supervision (SD) Ensuring carers and families are actively engaged with service developments (SU) (SD) Ensuring record keeping standards are in line with local protocols (SD) Core 1 C Core 2 PP Core 4 SI Core 5 Q	In-service training (SD) Attending relevant course(s) to support development of clinical knowledge e.g. Elklan BTec (SD) Core 2 PP Core 4 SI	SIG meetings (SD) Discussions with colleagues about clinical work (SD) (SU) Discussions with colleagues about service enhancement (SD) Core 1 C Core 3 HSS Core 4 SI Core 5 Q	Reading and reflecting (SD) (SU) Involvement in audit (SD) (SU) Core 2 PP Core 4 SI	Evidence of engagement with families/carers Evidence of learning outcomes from clinical supervision
Assistant Practitioners (Bands 4-5)	Analysing significant events /critical incidents (SD) Clinical Supervision (SD) Ensuring carers and families are actively engaged with service developments (SU)	In-service training (SD) Attending relevant course(s) to support development of clinical knowledge (SD) Core 2 PP Core 4 SI	SIG meetings (SD) Discussions with colleagues about clinical work (SU) (SD) Discussions with colleagues about service enhancement (SD) Core 1 C	Reading and reflecting (SU) (SD) Involvement in audit (SU) (SD) Core 2 PP Core 4 SI	As above Evaluation and reflection of training delivered.

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	(SD) Ensuring service user focus has been taken into account for all activities and service development (SU) (SD) Ensuring record keeping standards are in line with local protocols (SD) Assisting with or providing training beyond the SLT workforce eg parent workshops (SU) Evaluation of user views: collating views and preparing recommendations (SU) Core 1 C Core 2 PP Core 4 SI Core 5 Q		Core 3 HSS Core 4 SI Core 5 Q		
NQPs (if not within NHS consider 1-2 years' work experience)	Analysing significant events /critical incidents (SD) Analysing data relating to own service area (SD)	In-service training e.g. Record keeping (SD) Attending relevant course(s) to support development of clinical knowledge (SD) Attending multi	Journal club (SD) SIG meetings (SD) Discussions with colleagues about clinical work (SU) (SD) Discussions with	Reading and reflecting (SD) Involvement in audit (SU) (SD) Preparing reports/recommendations (SD)	Proactive use of qualitative and quantitative feedback to develop services Evidence of participation in clinical audit, including patient/service user

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Clinical Supervision (SD) Ensuring carers and families are actively engaged with service developments (SU) Ensuring service user focus has been taken into account for all activities and service development (SU) (SD) Developing skills to enable service users to self-manage (SU) Ensuring record keeping standards are in line with local protocols (SD) Develop skills around joint goal setting with users/carers (SU) Evaluating service user feedback (SU) clinical audit (SU) (SD) Designing and delivering training beyond the SLT workforce (SD) Participating in user	agency training relating to multi-disciplinary practice eg. Single assessment, lead professional (SD) Core 2 PP Core 3 HSS IK1	colleagues about evidence based/informed practice (SU) (SD) Discussions with colleagues about service enhancement (SU) (SD) Core 1 C Core 4 SI Core 5 Q	Researching role of voluntary agencies in relation to own client group (SU) (SD) Reading new policy and applying to own client group (SU) (SD) Core 2 PP Core 4 SI	involvement

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	groups (SU) Contributing to multi-disciplinary meetings around own clients (SU) To be an active member of a multi agency team (SD) Involvement in working with voluntary/service user groups (SU) Core 1 C Core 4 SI IK2 Core 6 ED HWB1 HWB2 HWB3 HWB4				
Band 6 (if not within NHS consider 3-5 years' work experience)	Analysing significant events /critical incidents (SD) Clinical Supervision (SD) Being part of a job rotation exercise to understand the roles of other professionals in relation to your role (SD) Working	Attending relevant conferences and providing written/verbal feedback to wider team (SD) Contributing to in-service training (SD) Attending relevant course(s) to support development of clinical knowledge (SD)	Journal club (SD) SIG meetings (SD) Discussions with colleagues about clinical work (SU) (SD) Discussions with colleagues on evidence based/informed practice (SU) (SD) Discussions with colleagues about	Researching and recording demographic data relevant to service (SU) (SD) Reading new policy and applying to own client group (SU) (SD) IK 1	To use clinical To demonstrate and reflect on a team approach to service delivery Evidence of empowerment of others – eg Undertaking practice based education for SLT students, parent/carer training

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	collaboratively with wider multi-disciplinary team (SD) Ensuring carers and families are actively engaged with service developments (SU) (SD) Ensuring service user focus has been taken into account for all activities and service development (SU) Ensuring record keeping standards are in line with local protocols (SD) Evaluating service user feedback contributing to service changes (SU) (SD) clinical audit (SD) Providing training beyond the SLT workforce (SU) (SD) Providing guidance for colleagues relating to own area of expertise (SD) To be an active member of a multi	Developing advanced communications skills as part of enhancing service delivery (SD) Core 2 PP Core 3 HSS	service enhancement (SD) Designing and delivering poster presentation (SD) Core 1 C Core 2 PP Core 4 SI		

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	agency team (SD) Involvement in working with voluntary/service user groups (SU) (SD) Core 1 C Core 2 PP Core 4 SI Core 6 ED IK 2 HWB 1-4 HWB 6				
Band 7 (if not within NHS consider 6-10 years' work experience)	Analysing significant events /critical incidents (SD) Clinical Supervision (SD) To be an active member of a multi agency team (SD) Involvement in working with voluntary/service user groups (SU) (SD) Ensuring carers and families are actively engaged with service developments (SU) (SD) Ensuring service user focus has been taken into account for all activities and service development (SU)	Conferences (SD) In-service training (SD) Attending relevant course(s) to support development of clinical knowledge (SD) Developing advanced communications skills as part of enhancing service delivery (SD) Attending policy events (professional, local, national) (SD) Core 1 C Core 2 PP	Journal club (SD) SIG meetings (SD) Leading discussions with colleagues about clinical work (SD) Leading discussions with colleagues about evidence based/informed practice (SD) Leading discussions with colleagues about service enhancement (SD) Designing and delivering poster presentation (SD) Appraising reflective writing (SD)	Researching and recording demographic data relevant to service (SU) (SD) Designing service evaluation questionnaires (SU) (SD) IK 1 IK 2	Contributing to governance/service organisation Evidence of supporting other members of staff in developing empowerment for a client centred approach. Evidence of creating a culture of quality assurance in developing staff, eg leading service users' involvement plan Develop a communication strategy for a core group or specialism

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Involving service users in evaluating accessibility to service for service users (including physical access, delivery of service, reasonable adjustments in line with DDA requirements) (SU) Evaluating service user feedback and leading on aspects of service change (SU) Leading the design and implementation of clinical audit involving other members of the MD team (SD) Reviewing specific aspects of provision within Service eg AAC (SD) Reviewing diversity policies and service inclusion of all population groups and leading on aspects of service change (SU) (SD) Implementing professional body standards and guidelines locally (SD)		Developing an evolving role (SD) Developing service with MDT/Integrated teams (SD) Core 1 C Core 2 PP Core 4 SI		

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Designing and delivering education packages contributing to additional qualifications for practitioners outside the SLT workforce (SD) Providing Clinical Supervision (SD) Promoting and ensuring client involvement in contributing to restructuring/ redesigning service (SU) (SD) Supervising other groups of staff eg other AHPs, nurses, health visitors, admin staff (SD) Core 1 C Core 2 PP Core 4 SI Core 6 ED IK 2 HWB 1-7				
Bands 8 and 9 (if not within NHS consider 10+ years' work experience)	Investigating significant events /critical incidents, together with developing and implementing action plan from lessons learnt (SD)	Conferences (leadership, research and development, multi-agency clinical events) (SD) In-service training linked to wider health agenda (eg public	Participation in regional groups/networks (SD) Journal club (SD) SIG meetings (SD) Discussions with	Researching and recording demographic data relevant to service (SU) (SD) Creating and analysing service evaluation questionnaires (SU) (SD)	Demonstrate patient focussed systems of care, continual service improvement and compliance with quality standards Strategic focus and improvement for whole

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Identifying trends and implementing service and systems changes to respond to these (SD) Ensuring clinical supervision is available for all members of the clinical team and monitoring the effectiveness of this (SD) Ensuring carers and families are actively engaged with service developments (SU) (SD) Ensuring mechanisms and systems for service user focus has been taken into account for all activities and service development eg aphasia friendly documentation (SU) (SD) Evaluating accessibility to service for service users (including physical access, delivery of service, reasonable adjustments in line with DDA	health, informatics) (SD) Attending relevant course(s) to support development of clinical knowledge Developing advanced communications skills as part of enhancing service delivery (SD) Attending policy events (professional, local, national) (SD) Core 1 C Core 2 PP	colleagues about clinical work and leadership (SD) Discussions with colleagues about evidence based/informed practice: promoting, embedding and evaluating (SD) Discussions with colleagues about service enhancement (SD) Appraising reflective writing (SD) Developing an evolving role (see RCSLT policy statement for details) (SD) Developing service with MDT/Integrated teams (SD) Action learning sets (SD) Contributing to professional through regional groups and RCSLT (SD) IK 1 IK 2	Using Q-SET to review services and improve provision (SU) (SD) Journal reading and dissemination of learning to colleagues (SD) Reading strategic national documents and disseminating relevant information to colleagues Core 2 PP IK 1 IK 2	service Evaluate the impact of service reviews across a service Evidence of regularly evaluating user feedback and demonstration of how this influences service design and delivery

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	requirements) and adjusting services accordingly (SU) (SD) Leading programmes of clinical audit, including service user contributions (SU) (SD) Undertaking full services reviews with written reports and action plans and progress reviews (SD) Writing business plans and demonstrating involvement of partners in completing these (SD) Negotiating with commissioners (SD) Reviewing diversity policies and service inclusion of all population groups and actively promoting wider access (SU) (SD) Implementing and maintaining professional body standards and guidelines locally (SD)				

Client-centred assessment and management/enablement including client self-management, health promotion, goal setting					
SU – engagement with service users SD – enhancement of service delivery **KSF**	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Restructuring/ redesigning service (SD) Supervising other groups of staff eg other AHPs, nurses, health visitors, admin staff (SD) Developing strategic approach to service delivery and working with Strategic partnerships (SD) All Core HWB 1-7				

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Participating in clinical supervision, appraisal/PDP NA Being part of a project team NA DE Shadowing a colleague and reflecting on this DE Visiting other departments to identify relevant good practice and reporting back DE Contributing to collation of service user views under direction of SLT DE Core 1 C Core 2 PP Core 4 SI Core 5 Q	Foundation degree DE BTec Courses DE Attending Support Workers Conference RCSLT DE Core 2 PP IK 3 G 2	Contribution at Staff meetings within SLT service or other Multi disciplinary teams of which they are members NA Input to annual service reviews and business plans NA DE Contribute to workforce planning discussions & service discussion with colleagues in other services NA Support workers SIGs Linking with support workers from other disciplines and agencies NA Core 1 C Core 4 SI Core 5 Q	Awareness of current trends e.g. local policy development, NICE / NHS directives etc. DE Contribute to role of support workers in changing landscape. NA Developing an understanding or awareness of the role of others in the delivery of care. NA Responding to client's needs, reporting back through appropriate channels NA Reading relevant publications including service policies DE Searching patient/user websites including voluntary sector/support groups NA DE Core 2 PP IK 2	Contribute to the success of projects and the delivery of the service CPD and fuller understanding of role as evidenced by work practice.
Assistant Practitioners (Bands 4-5)	Attending Clinical Supervision NA Collation/evaluation of service trends/data	Attend local multi-agency training on approaches to seeking service user views e.g. advocacy, discovery	Attending relevant SIG meetings NA Evaluating accessibility to service for service	Awareness of current trends e.g. local policy development, NICE / NHS directives etc. DE	

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	under direction of SLT DE Being part of a project team NA DE Ensuring carers and families are actively engaged with service developments, as guided by SLT NA Ensuring service user focus has been taken into account for all activities and service development NA Evaluating service user feedback, if delegated by SLT DE Shadowing a colleague and reflecting on this DE Visiting other departments and reporting back DE Core 1 C Core 2 PP Core 4 C Core 5 Q Core 6 ED	interviews NA As above, Foundation degree/BTec DE Presenting or contributing to the planning of support workers and assistants events NA Core 2 PP G1	users (including physical access, delivery of service, reasonable adjustments in line with DDA requirements) DE Participating in a steering group for a discrete project NA Trialling new ways of working and participating in evaluation. This may be in partnership with workers form other disciplines and agencies DE Core 1 C Core 2 PP Core 6 ED	Contribute to role of support workers in changing landscape. Developing an understanding or awareness of the role of others in the delivery of care. NA Responding to client's needs, reporting back through appropriate channels NA Reading relevant publications including service policies DE Searching websites DE Core 2 PP	
NQPs (if not within NHS consider 1-2 years' work experience)	Contributing to Clinical Supervision NA Being part of a project team NA DE	Attending relevant course(s) to support development of clinical knowledge eg Signalong,	Attending SIG meetings DE Evaluating accessibility to service for service	Completing local preceptorship requirement NA Contributing to service	Completing NQP framework Move to more independent level of

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Presenting case for change to peers/small local team DE Ensuring carers and families are actively engaged with service developments NA Ensuring service user focus has been taken into account for all activities and service development NA DE Evaluating service user feedback NA DE Contributing to clinical audit DE Shadowing a colleague and reflecting on this DE Visiting other departments and reporting back DE Inputting to local clinical governance initiatives NA DE Core 1 C Core 2 PP Core 5 Q Core 6 ED G 5 SPM IK 2	Conversational Partners NA Attending on the job/in-house training eg Procedures, Record keeping Time tabling Report writing Effective clinical decision making DE NA Employers Mandatory training eg Infection control, resuscitation NA Core 2 PP	users (including physical access, access to information delivery of service, reasonable adjustments in line with DDA requirements) DE Participating in a steering group for a discrete project NA Core 1 C Core 6 ED	redesign and development initiatives NA Reading RCSLT Bulletin and Journal DE Reflective practice NA Building knowledge of other professions/agencies and relevant voluntary organisations NA Developing appreciation of workings of employing organisation eg NHS Commissioner/Provider split NA Core 2 PP Core 4 S	practice AfC Competencies /KSF gateways achieved

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
Band 6 (if not within NHS consider 3-5 years' work experience)	Contributing to Clinical Supervision NA Being part of a project team NA DE Preparing and presenting a case for change as a basis for improvement NA DE Ensuring carers and families are actively engaged with service developments NA Ensuring service user focus has been taken into account for all activities and service development NA Evaluating accessibility to service for service users (including physical access, access to information, delivery of service, reasonable adjustments in line with DDA requirements) NA Evaluating service user feedback DE Involvement in wider work of employer (for example, being a representative on a committee) NA	Conferences relating to clinical area eg DE Attending relevant course(s) to support development of clinical knowledge eg DE Attending and providing on the job/in-house training eg New systems New assessments NA Attending one to one coaching NA Providing one to one coaching, when appropriate NA Core 2 PP G1 LD	Attending SIG meetings relevant to work area NA DE Discussions with colleagues about service enhancement NA Participating in departmental benchmarking, application for awards DE Participating in a steering group for a discrete project NA Being appraised as part of a peer review exercise DE Core 1 C Core 2 PP Core 4 SI	Researching examples of best practice DE Using service redesign tools as part of the wider team or redesign project NA DE Researching relevant current policy NA Searching for and using up to date research to inform service redesign NA DE Appraise and apply multidisciplinary and multiagency working to improve service to users NA Develop new and comprehensive ways of involving and consulting users and carers NA Core 4 SI IK 2	Contribute options for service improvement Recognise limitations and boundaries of scope of practice and knows when to seek advice Monitor service improvement within their clinical area

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Designing and implementing clinical audit DE Representing employer at local level NA Undertaking a secondment in a related area of work NA Inputting to local clinical governance initiatives NA Supervising staff/ assistants NA Supervising SLT students on placement NA Core 1 C Core 2 PP Core 6 ED G 5 SPM IK 2				
Band 7 (if not within NHS consider 6-10 years' work experience)	Attending and leading Clinical Supervision NA Leading a project team DE NA Ensuring carers and families are actively engaged with service developments NA DE Ensuring service user focus has been taken	Contributing to Conferences within specialist area and wider health/MD area eg NA DE Management Training and leadership development NA DE Project Management NA DE	Contributing to and leading SIG meetings as a SIG committee member NA Initiating discussions with colleagues about service enhancement NA DE Participating in a steering group for a discrete project NA DE	Researching and recording demographic data relevant to service DE Designing service evaluation questionnaires NA DE Appraise and apply examples of best practice to shape service improvements	Ensure service improvements introduced and evaluated and link to organisational plan Creating project plans and timeframes Lead with multi-agency group around area of service improvement

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	into account for all activities and service development NA DE Evaluating accessibility to service for service users (including physical access, access to information, delivery of service, reasonable adjustments in line with DDA requirements) NA DE Involvement in wider work of employer (for example, being a representative on a committee) NA Designing, implementing and reporting of clinical audit DE Representing employer at local level NA Reviewing provision within Service Reviewing diversity policies and service inclusion of all population groups NA DE Carrying out induction for new staff NA Inputting to local	Attending relevant course(s) to support development of clinical knowledge eg NA Organising and presenting in-service training NA DE Providing training beyond the SLT workforce NA Attending policy events (professional, local, national) NA HR training (eg interview and selection, undertaking appraisals NA Leadership training NA DE Core 1 C Core 2 PP G 1 LD	Reviewing diversity policies and service inclusion of all population groups NA Being appraised as part of a peer review exercise DE Implementing professional body standards and guidelines locally DE Chair of Committee NA Involvement in completion of Q-SET DE Completion of RCSLT National Standards for Practice Based Learning - audit tool DE Developing service with MDT/Integrated teams NA Implementation of Q-SET action plan NA DE Implementing national policy locally NA Representing professional body at national level NA Strategic meetings with	NA DE Using service redesign tools NA DE Researching relevant current policy and demonstrating how this influences developments NA Searching for and using up to date research to inform service redesign NA DE Reading relevant national and local policies and frameworks DE Core 2 PP Core 4 DI IK 2	Prepare outline business case/formal proposals for provider board reports

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	clinical governance initiatives DE Supervising staff. Ensuring full induction processes are adhered to with feedback from inductee NA Supervising SLT students on placement NA Assessing personal development plans and KSF/IPR NA Developing an evolving role/advanced skills specific to client group NA DE Implementing employers policies NA Managing a project team DE Core 1 C Core 2 PP Core 4 SI Core 5 Q Core 6 ED G 5 SPM G 6 PA G 7 C+C		relevant stakeholders eg. 3rd sector partners/LA/HEI/School NA DE Representing professional body at national level NA DE Core 1 C Core 2 PP Core 4 SI Core 5 Q Core 6 ED IK 2		

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
Bands 8 and 9 (if not within NHS consider 10+ years' work experience)	Attending, contributing to, leading and facilitation Clinical Supervision + appraisals NA Leading a project team DE Ensuring carers and families are actively engaged with service developments NA Ensuring service user focus has been taken into account for all activities and service development NA Evaluating accessibility to service for service users (including physical access, access of information, delivery of service, reasonable adjustments in line with DDA requirements) NA Involvement in wider work of employer (for example, being a representative on a committee) NA Overseeing programme of clinical audit in team/specialist area NA	Attending and presenting at relevant conferences NA DE Organising and presenting in-service training NA Providing training beyond the SLT workforce NA Attending policy events (professional, local, national) DE Financial planning training DE HR training (eg interview and selection, undertaking appraisals NA DE Leadership training NA MCA Training NA Management / leadership training – higher clinical degree training DE Core 2 PP G 1 LD	Involving colleagues in service enhancement within the framework of a service development plan NA Initiating / Leading a steering group for a discrete project NA Reviewing diversity policies and service inclusion of all population groups NA Being appraised as part of a peer review exercise NA Implementing professional body standards and guidelines locally NA Completion of Q-SET DE Completion of RCSLT National Standards for Practice Based Learning - audit tool DE Developing service with MDT/Integrated teams NA Leading on Implementation of Q-SET action plan DE Implementing national	Researching and recording demographic data relevant to service DE Filling in service evaluation questionnaires and developing a resulting action plan NA Work in partnership with others to promote and evaluate service development NA Reading relevant national and local policies and frameworks and maintaining up-to-date knowledge of relevant legislation DE Core 2 PP Core 4 SI IK 2	Ensure junior staff have supervisory programmes in place and all staff meet objectives Identify staff needs Ensure Patient feedback mechanisms are in place and participation has taken place PPI in place with evidence of communication-friendly letters/information being used appropriately Regular risk assessments undertaken and acted upon Advocacy/consent aided support in line with MHA and MCA Evidence of reviews of service policies and evidence of identified areas of development/service changes as a result of audit. Knowledge of role redesign/modernisation

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Creating annual service plan with partners and reviewing progress 6 monthly NA Developing service specifications or SLAs. Leading annual service specification review NA Troubleshooting SLAs with stakeholders on regular basis NA Reviewing diversity policies and service inclusion of all population groups/ Contribute to feedback to employer on HR policies NA Contribute to employer's audit process and other audit mechanisms (e.g. JAR) NA Recruiting appropriate staff to deliver services NA Initiating professional development programmes to ensure workforce are able to deliver redesigned services NA Carrying out induction		policy locally NA Leading a Peer review exercise NA Being a QAA reviewer DE Representing professional body at national level DE Being a Clinical Advisor for RCSLT DE Core 1 C Core 2 PP Core 6 ED IK 2		of workforce Knowledge and understanding of risk factors involved in role redesign Production and review of job descriptions, roles and recruitment that will meet service demand Make significant contributions to workforce planning Evidence of activity on relevant working groups and committees Evidence of having adhered to policies, service specifications, clinical governance reports Promote leadership across agencies Ensure strong local accountability Promote and support the use of relevant data in order to plan service delivery

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	for new staff – ensuring appropriate CRB etc DE Supervising SLTs in relation to service planning NA Supervising staff/ assistants in relation to service planning NA Assessing personal development plans in relation to service planning NA Initiating MD steering groups and overseeing efficient running of groups (Chair, minutes, actions) DE Developing an evolving role NA Implementing employers policies NA Representing employer at national level NA Restructuring/ redesigning service NA Supervising other groups of staff e.g. other AHPs, nurses, health visitors, admin staff NA				

Service planning and organisation including use of health trends data, service and skills/ role redesign					
NA= Needs Assessment DE = Data Evaluation KSF	**Work based activity**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning**	**Outcomes**
	Budget reporting DE Working in partnership with service commissioners to identify needs and develop targeted services NA Strategic meetings with relevant stakeholders eg 3rd sector partners/LA/HEI/School NA Core 1 C Core 2 PP Core 4 SI Core 5 Q Core 6 ED G 4 FM G 5 SPM G 6 PM G 7 C+C IK 2				

CPD Framework – Education and Learning *including of self (CPD), clients, colleagues, students, the public*					
Growing and developing self=**GDS** Growing and developing others =**GDO** **KSF**	**Work based activity** **For all:** **Personal Development Reviews (PDR)** **Clinical Supervision**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning** **For all:** **Reflective CPD log**	**Outcomes**
Support Workers (bands 2-3)	Parental training delivery of courses devised by SLTs – Band 3 **GDO** Ability to facilitate and empower carers/ parents/users **GDO** Delivery "off the peg" training – Hanen at assistant level following training **GDO** Will prepare resources for training but don't design training packages **GDO** **G1 L&D** **CORE2 P&P**	Attend as appropriate **GDS** Identify needs for formal education and support **GDS** NVQs **GDS** Training around consent and duty of care **GDS** **G1**	Peer based learning Local groups Shadowing **GDS** **G1** **CORE 1**	Web based searches for relevant information **GDS** Reading relevant publications **GDS** **CORE1** **IK3**	Preparing resources. Facilitating events. Publicising service e.g. manning stands at conferences or study days, giving out information.
Assistant Practitioners (Bands 4-5)	Modelling strategies e.g. How to run a group for other staff **GDO** May be "shadowed" by SLT student and SLT in preceptor/NQP year **GDO** Deliver training designed by others **GDO** **G1 L&D** **CORE2 P&P**	NVQ / BTec / Foundation degree **GDS** In house training **GDS** Identifying needs, reflecting on gaps and development **GDS** Mandatory training **GDS** **CORE2 P&P**	Assistants SIG Peer networks Shadowing Relevant SIGs **GDS** **CORE 1**		Supporting colleagues Band 3 through demonstration of work based activities Induction Publicising service as part of public information

CPD Framework – Education and Learning
including of self (CPD), clients, colleagues, students, the public

Growing and developing self=**GDS** Growing and developing others =**GDO** **KSF**	**Work based activity** **For all: Personal Development Reviews (PDR) Clinical Supervision**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning** **For all: Reflective CPD log**	**Outcomes**
NQPs (if not within NHS consider 1-2 years' work experience)	Feeding into a group designing training **GDO** Delivering training in partnership with more experienced staff (shadowing trainer) **GDO** Learning from feedback Seeking pointers for change/improvement **GDS** Case discussions Seeking 2nd opinions **GDS** **G1 L&D CORE2 P&P HWB1**	Mandatory training as set by employer e.g. Preceptorship scheme **GDS** RCSLT NQP framework **GDS** Outside courses as identified in Appraisal and Personal Development plan **GDS** **G1 CORE2**	Peer discussion **GDS** Clinical Supervision **GDS** Journal Clubs/ skill sharing **GDS** NQP SIGs **GDS** **CORE 1 CORE 2 G1**	Reading Journals **GDS** Web searches **GDS** Shadow others **GDS** Accompanying patients to specialist centres **GDO** Looking to wider network e.g. RCSLT Advisors/ Bulletin **GDS** **CORE2 IK3**	NQP framework completed with full details for section 2 Improving skills in presentation & training. Having clear picture of personal learning needs. Assist in PR events.
Band 6 (if not within NHS consider 3-5 years' work experience)	Designing and delivering training – supported by evidence **GDO** Identifying training needs of others **GDO** Using feedback and reflection to improve skills **GDS** Taking on undergraduate SLT students and other professions **GDO**	Specialist training – post graduate Clinical Educators Courses **GDS** Presenting at conferences **GDS** **G1 CORE2 CORE5**	Specialist area SIGs **GDS** Active role in SIGs **GDS** Journal Clubs **GDS** Presenting cases and journal papers **GDS** Supporting leaders of SIGs **GDS** Mentoring juniors **GDO** **CORE 1**	All the above. Identifying learning needs and how best to meet them **GDS** **CORE2 IK3 G1**	Developing/Delivering training. Responsibility for students. Informing public about postholder speciality. Co-ordinate information sessions. Prepare publicity info/events. Developing enhanced

CPD Framework – Education and Learning *including of self (CPD), clients, colleagues, students, the public*					
Growing and developing self=**GDS** Growing and developing others =**GDO** **KSF**	**Work based activity** **For all:** **Personal Development Reviews (PDR)** **Clinical Supervision**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning** **For all:** **Reflective CPD log**	**Outcomes**
	Identifying learning styles of others **GDO** Critically evaluate – marking/grading submissions **GDO** **G1 L&D** **CORE2 P&P** **HWB1**		**CORE 2**		critical appraisal skills for higher level of analysis of research
Band 7 (if not within NHS consider 6-10 years' work experience)	All of above and leading, co-ordinating a team's delivery of training in more specialist areas **GDO** Leading CPD activities for others in team **GDO** Analysing gaps in team's knowledge and skills **GDO** Leading SIGs **GDO** Active in regional professional networks **GDS** Working with other disciplines and agencies to devise pathways Actively looking for new evidence/ activities in relevant field **GDS** Influencing models and	Contributing to position papers **GDS** Post graduate training M level modules **GDS** Team leader training **GDS** Facilitation skills training **GDO** Advanced report writing **GDS** **G1** **G5** **CORE 4**	Conducting personal development reviews **GDO** Writing development plan for junior roles **GDO** Supporting others in their learning **GDO** Collating evidence base for others **GDO** **IK3** **CORE 2** **CORE 4** **CORE 5** **G1**	Developing the evidence base **GDO** Reflecting on gaps in evidence/critical appraisal linking with area MDT **GDO** Joint development of education/learning **GDO** Leadership challenge events – new roles **GDS** **CORE 2** **CORE 4** **CORE 5**	All the above. Leading patient focus groups. Student placement co-ordinator. Presenting to HEIs. Challenge own boundaries. Ensuring team learning needs feeds into organisational planning. Evaluating training and using that to inform change. Critically appraise methodology, delivery, content etc. Advanced understanding of

CPD Framework – Education and Learning *including of self (CPD), clients, colleagues, students, the public*					
Growing and developing self=**GDS** Growing and developing others =**GDO** **KSF**	**Work based activity** **For all:** **Personal Development Reviews (PDR)** **Clinical Supervision**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning** **For all:** **Reflective CPD log**	**Outcomes**
	providing in-house updates **GDS** **G1 L&D** **CORE2 P&P** **HWB1**				research/audit methodology
Band 8 (if not within NHS consider 10+ years' work experience)	Strategic overview of training and learning, linking into research, policy and national strategy **GDS** Anticipating learning needs and training for team – linking with academic others to forward plan provision of training **GDO** Contributing to undergraduate modules as an external tutor **GDO** Providing expert advice/training to external professional groups in highly specialist areas **GDO** Linking with Regional Groups, SHA or country equivalents to plan training strategies **GDS** Workforce planning: Profiling to inform	Masters level education and above **GDS** Specialist conference and courses **GDS, GDO** Leading conference sessions/papers **GDO** Delivering undergraduate and post graduate training to a variety of disciplines **GDO** Organising and running conferences having identified need – multi professional /multi agency **GDO** Advanced finance management **GDS** Project Management **GDS** Change Management **GDS**	Identifying need for SIGs setting up SIG and evaluating the impact of SIG activities **GDO** Accessing/Leading **GDO** Regional support groups Linking with RCSLT initiatives to contribute to the development of SLT workforce **GDO** Multi professional peer groups **GDO** Extended scope of practice **GDS** **G1** **CORE 1** **CORE 2** **CORE 4** **CORE 5**	All of above Leadership/mentorship **GDO** Coaching **GDO** Action Learning Sets **GDO** Reflecting on service direction **GDO** Horizon Scanning **GDS** Identifying broad range of skills needed – business skills **GDS** **CORE 1** **CORE 2** **CORE 4** **CORE 5**	Departmental learning: judging need of apportioning resources Ensuring workforce is trained to deliver what is commissioned. Setting up public consultations. Strategies for PPI. Informing media/press releases. Informing local politicians and national debate Contributing to national campaigns Promoting the profession to the public. Influencing Acting as specialist advisor to strategic policy groups

CPD Framework – Education and Learning *including of self (CPD), clients, colleagues, students, the public*					
Growing and developing self=**GDS** Growing and developing others =**GDO** **KSF**	**Work based activity** **For all:** **Personal Development Reviews (PDR)** **Clinical Supervision**	**Formal Education e.g. courses and conferences**	**With SIGs or peers**	**Self-directed learning** **For all:** **Reflective CPD log**	**Outcomes**
	commissioning of undergraduate placements **GDS** Contributing to the development of policy in specialist areas **GDO** **G1 L&D** **CORE2 P&P** **CORE 4 SI**	Meeting management e.g. chairing skills and writing briefing papers **GDO GDS** **G1** **G2** **G4** **G5**			Acting as RCSLT rep on regional clinical forums

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Attending In-service training, professional induction approaches Supervision Discussions with colleagues about evidence based/informed practice Analysis of job description Involvement in wider work of employer (for example, being a representative on a committee) Implementing diversity policies and service inclusion of all population groups in practice Core 6 ED level 1 & 2 Core 1 level 1 & 2 Core 2 PP level 1	NVQ HNC Mandatory training Induction Undertake relevant e-learning Core professional practice standards, eg: consent, ethical considerations, confidently as relevant to specific role Core 2 PP level 1	Attending SIG meetings Attending internal meetings Responding to relevant RCSLT consultations	Collecting evidence for KSF/ HPC/ RCSLT CPD Diary Read and reflect on RCSLT policy statements relating to SLTs	Keep reflective diary to evidence learning – KSF/ appraisal requirements Reflect on and work within: • professional boundaries, • professional guidance and standards • organisational policies and procedures Implementation of information/ learning resources in practice in order to support best outcomes for service users
Assistant Practitioners (Bands 4-5)			Leading support worker meetings Networking with colleagues in other departments Sharing learning and resources with peers Core 1 level 1 & 2	Reading relevant documents Core 2 PP level	
NQPs (if not within NHS consider 1-2 years' work experience)	**As above PLUS** Complete NQP framework and implement learning from framework	**As above PLUS** Attend clinical supervision Attend relevant	**As above PLUS** Critical appraisal of current research Data collection to	**As above PLUS** Reflective process against HPC standards + KSF outline	**As above PLUS** Completed CPD diary that meets standards of HPC EB approach in practice

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Understand and achieve performance targets – eg: WL, activity, etc Core 2 PP level 1	accredited courses Achieve relevant competencies – eg: dysphagia Undertake e-learning, eg: bilingualism Core 2 PP level 1	contribute to audits, service evaluation, R&D pilots 1K2 level 1 & 2	Reflection identifying gaps > evaluations, research questions Core 2 PP level 1	Signed off by RCSLT NQP framework Meets KSF profile for band 5 Clear understanding of personal accountability in professional role
Band 6 (if not within NHS consider 3-5 years' work experience)	**As above PLUS** Being appraised as part of a peer review exercise Carrying out induction for new staff Inputting to local clinical governance initiatives, eg: contributing to audit and PPI measures Organising and presenting in-service training, eg: updates on specific service development Reviewing diversity policies and service inclusion of all population groups (mandatory training)	**As above PLUS** Introduction to management/ leadership training Clinical governance training Risk assessment training Connecting for Health Information Governance training Core 2 PP level 1	**As above PLUS** Leading on journal clubs/similar for local dept Responding to RCSLT consultation on position papers and policy statements Core 2 PP level 1 G1 LD level 2	**As above PLUS** Portfolio evidence shows reflection and changes to practices based on the reflection are evidenced for KSF Reviewing HPC standards at each renewal period Reading relevant sections of CQ3, position papers, and implementing when relevant Core 2 PP level 1	**As above PLUS** Meets the higher level KSF profile for band 6 Full understanding of personal accountability and accountability of rest of the team Learning is wider than impact of SL tie considers the impact of condition on whole person Knowledge of RCSLT and HPC documentation and standards is up to date

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Design and implement clinical audit + action plan Inputting to local clinical governance initiatives Supervising SLTs Supervising assistants Supervising students on placement – any stage Core 2 PP level 1				
Band 7 (if not within NHS consider 6-10 years' work experience)	**As above PLUS** Supervising research projects Leading on service quality monitoring, eg: activity monitoring per therapist, analysis of data for outcomes for interventions, access times to sub service they are lead for. Providing evidence for Care Quality Commission standards. Responding to complaints and carrying out learning cycle following complaints	**As above PLUS** Attending policy events (professional, local, national) Leadership training Organising/ running accredited/registered courses Formal learning re clinical governance activity within organisation, eg: audit, audit cycle, research activity/ knowledge skills, measuring outcomes for pathways,	**As above PLUS** Being an RCSLT advisor Developing position papers for RCSLT Responding to RCSLT position paper consultations Arranges training to colleagues wider than own local area eg: across region Core 1 level 2, 3 & 4	**As above PLUS** Relevant reading Service planning Core 2 PP level 2 & 3 Core 4 SI level 2, 3 & 4	**As above PLUS** Achieves band 7 KSF competencies Leading meetings and discussions to solve problems and make decisions Present and promote the work of the team/ service/ organisation to relevant stakeholders

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Developing care pathways and standards for service area Collating with colleagues evidence based/ informed practice and auditing services Identifies staff who may need additional support in capability to HR or band 8 Undertake strategic overview for a team Inputting to local clinical governance initiatives/ audit Providing clinical supervision Carrying out induction for NQPs Being an expert witness G1 LD level 2 Core 1 level 2 & 3 HWB 2 level 3 & 4	pathway development Delivery of formal training, eg: clinical supervision Core 2 PP level 1 & 2 G1 LD level 2 & 3			

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
Band 8 (if not within NHS consider 10+ years' work experience)	**As above PLUS** Developing/ contributing to policy in multidisciplinary context Completion of RCSLT National Standards for Practice based Learning – audit tool Developing an evolving role with SLT Developing pathways with MDT/Integrated teams Implementation of Q-SET action plan Leading a Peer review exercise Meeting with service commissioners Signing off NQP framework Attends organisations governance steering group and implements actions required Contributes to writing of organisational policies	**As above PLUS** Learning in Project management frameworks Masters level training in leadership/ clinical area Root cause analysis training G1 LD all levels Core 2 PP level 2	**As above PLUS** Being an RCSLT advisor Leading on position papers/ policy statements/ guidelines for RCSLT Responding to position paper consultations Attending regional SLT meetings Being an RCSLT rep on a Board/ Council Core 1 levels 3 & 4	**As above PLUS** Learning linked to wider political influences/national documents – online, national papers Core 2 PP level 2 & 3	**As above PLUS** Service review document available to evidence governance against Care quality Commission standards/ outcomes QSET completed for service with action plan and shared with relevant stakeholders Business plan and outcomes on a yearly basis linked to local strategy plan Identify and implement key performance indicators for the team (eg: prioritising vulnerable groups/ the service user experiences) Identify and improve the development of team member to ensure that meets the needs of the team/ service/ organisation

CPD Framework – Accountability and performance governance standards *(including clinical, financial and managerial)*					
Implementing governance/standards(I) Developing quality assurance and standards (D) **KSF**	**Work based activity**	**Formal Education eg: face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Leads on services local policies Implements disciplinary process Report to board, local groups and local authority scrutiny groups Provides data for setting activity targets, access times, analyses service based on local demographics and capacity to provide within funding Writes business cases to ensure safe services Implements NPSA 7 steps to safety across dept. Creates a business plan yearly to link to local and national drivers Core 1 level 3 & 4 Core 2 PP level 3 & 4 Core 4 SI all levels Core 5 Q all levels G1 LD all levels				

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
Support Workers (bands 2-3)	Attending in-service training on SLT interventions Discussions with colleagues about evidence based/informed practice Evaluating accessibility to service (eg: format, use of symbols) for service users (including physical access, delivery of service, reasonable adjustments) Peer supervision/ support reflection Working with SLTs in groups Shadowing peers/ SLTs Attend team meetings Adapting communication style to meet service users needs, eg: simplify language levels/ vocabulary, use of sign symbol text Feeding back therapy advice to parents/ carers or support workers	Attending conferences Specific training courses - eg: knowledge of language levels such as in Derbyshire Language Scheme; use of signing programmes such as Makaton/ Signalong etc Core 2 PP level 1	Attending SIG meetings Running journal clubs Inputting to events for Assistants run by RCSLT Core 1 communication level 2	Reflective practice Reading bulletins/ journals/ relevant books Online info/ e-learning Core 2 PP level 1	Effective intervention with clients Deal with first line queries/ complaints Working to demonstrate carers and families are actively engaged with clinical activities to ensure best outcomes Ensuring service user focus has been taken into account for all activities and service development Show evidence of understanding clinical activities and required outcome for individual groups Developing knowledge/ skills in a specific area
Assistant Practitioners (Bands 4-5)					

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Explaining the service to service users including eligibility criteria All – Core 1 level 2 Core 2 PP level 1 & 2				
NQPs (if not within NHS consider 1-2 years' work experience)	**As above PLUS** Evaluating accessibility to service (eg: format, use of symbols) for service users (including physical access, delivery of service, reasonable adjustments in line with DDA requirements) Model how to adapt communication style to others such as parent/ support workers, give advice on language levels and appropriate techniques to use Involvement in wider work of employer (for example, being a representative on a committee) Running groups for parents/ carers	**As above PLUS** Attends relevant courses – eg: Makaton; Accessible information training; Signing training; Talking Mats training Core 2 PP level 2 & 3 G1 LD level 1 & 2	**As above PLUS** Attends relevant SIGs and contributes to their CPD activity Participating in local campaigning initiatives, eg: organising flashmobs to promote SLT and service users' needs Core 2 PP level 1 & 2	**As above PLUS** Completing learning styles questionnaire Reading NICE policy on Public and Patient involvement Undertaking RCSLT bilingualism e-learning Reading Communication Matters Core 2 PP level 1	**As above PLUS** Ensuring carers and families are actively engaged with clinical activities and service developments Effective communication with MDT Effective clinical decision making and communication with clients Supporting the production of accessible materials Cascading knowledge/ skills to Assistants and other colleagues in MDT

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Attending supervision/ requesting support and undertaking reflection on this Highlighting own learning needs to supervisor Contributing to service meetings Core 1 level 2 & 3 Core 2 PP level 2 & 3 HWB 9 level 1 & 2				
Band 6 (if not within NHS consider 3-5 years' work experience)	**As above PLUS** Reviewing communication systems, eg: AAC provision within Service/ for individuals Reviewing diversity policies and service inclusion of all population groups, making materials accessible to others Being appraised as part of a peer review exercise Carrying out induction for new staff Organising and presenting in-service training/ external training specifically on how to	**As above PLUS** More specialist training including undertaking training to be able to train other professionals Core 2 PP level 2	**As above PLUS** Member of a SIG Committee and leads on the CPD activity for the group in consultation with RCSLT adviser Responding to RCSLT position paper consultations Core 2 PP level 2	**As above PLUS** Internet searches/ online info/ e-learning Independent reading (Bulletin/ journals/ relevant books) Reflective practice on how own communication skills have been enhanced Core 2 PP level 1	**As above PLUS** Ensuring service operates in line with DDA requirements Effective communication around developing area of clinical expertise Effective clinical decision-making and the ability to talk to it/ about it to parents, carers, the person and the MDT Understanding audience and adjusting communication accordingly Training courses delivered

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	communicate with people with SLCN Running awareness-raising courses for carers, eg: dysphagia awareness Receiving supervision Supervising SLTs Supervising assistants Supervising students on placement Core 1 level 3 Core 2 PP level 2 & 3 G1 LD level 2 & 3				SLT perspective representative outside of own professional group Proposing change in service as a result of learning and reflection
Band 7 (if not within NHS consider 6-10 years' work experience)	**As above PLUS** Being an expert witness Attending tribunals Recruitment of new staff Completion of RCSLT National Standards for Practice Based Learning – audit tool Developing the role in line with new evidence/ innovations	**As above PLUS** Attending policy events (professional, local, national) Giving presentations at conferences Business and Leadership training, awareness of personality types and communication preferences	**As above PLUS** Being an RCSLT advisor Commenting on and Developing position papers – ensuring that service user risks and benefits are clearly set out Core 1 level 3 & 4	**As above PLUS** Critical appraisal of journal articles Providing constructive feedback to consultants Use Myers Briggs/ Belbin or similar analyses to strategically plan own development needs and those of the team Core 2 PP level 2	**As above PLUS** Able to represent the profession at a formal event/ activity Creation of profession-specific documentation Increased knowledge and skills to expanding client group Developing knowledge/ skills in a specific area Using knowledge to create change in services, develop

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Developing pathways with MDT/ integrated teams/ multi-agency networks Implementation of Q-SET action plan and discussion of Q-SET results with commissioners (or equivalent) Involvement in wider work of employer (for example, being a representative on a committee) + multi-agency representative Contributing to business objectives and local action plan Providing clinical supervision Supervising research projects Carrying out PDRs for staff Providing licensed/accredited training Responding to complaints Core 1 level 3 & 4 Core 4 SI level 3 Core 5 Q level 3 & 4	Organising accredited/registered courses Complaints management training Incident analysis report writing training G1 LD level 2 Core 2 PP level 2			business cases Managing difficult clients, complaints and challenging situations Demonstrate improvements in outcomes/ service delivery Producing business plan for personnel requirements or for resources Enhanced team working through a range of activities

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
Band 8 (if not within NHS consider 10+ years' work experience)	**As above PLUS** Developing an evolving SLT role and achieving support for this with relevant stakeholders Developing service with MDT/integrated teams, lead multi-agency meetings Analysis of Q-SET data/ local data; convey the analysis of the data to board, commissioners and the impact of the lack of service linking to local and national drivers Leading a peer review exercise Leading a team - communicating the organisation's goals and the service vision in order to effectively lead the team Meeting with service commissioners, communicating the outcomes that SLT has on the local population and identifying those priorities that are key locally	**As above PLUS** Developing courses to be presented by self or others G1 LD level 2 & 3 Core 2 PP level 2 & 3	**As above PLUS** Representative on RCSLT Boards Submission of journal articles or Bulletin articles to showcase service achievements Core 1 level 3 & 4	**As above PLUS**	**As above PLUS** Creation of documentation to be accessed beyond SLT profession Sharing of knowledge within SLT workforce and beyond Able to demonstrate improved capacity/service provision – quantitatively and qualitatively

CPD Framework – Communication *(including with clients, colleagues, MDT, commissioners, the public)*					
Communication within the SLT workforce (W) Strategic/external facing communication (E) **KSF**	**Work based activity**	**Formal Education e.g. face-to-face or online courses and conferences**	**Professional Activities with SIGs, peers or professional body**	**Self-directed learning**	**Outcomes**
	Signing off NQP framework and analysing the NQP evidence to ensure it meets the standards Presenting info at Board level re the SLT service Awareness raising for service to commissioners/ stakeholders Raising the profile of SLT to the wider community and relevant commissioners and the outcomes to be achieved Core 1 level 3 & 4 Core 2 PP level 3 & 4 Core 4 SI level 3 & 4				

Supervision

Guidance for occupational therapists and their managers

College of Occupational Therapists

College of Occupational Therapists

About the publisher

The College of Occupational Therapists is a wholly owned subsidiary of the British Association of Occupational Therapists (BAOT) and operates as a registered charity. It represents the profession nationally and internationally, and contributes widely to policy consultations throughout the UK. The College sets the professional and educational standards for occupational therapy, providing leadership, guidance and information relating to research and development, education, practice and lifelong learning. In addition, 11 accredited specialist sections support expert clinical practice.

College of Occupational Therapists

www.COT.org.uk

Supervision

Guidance for occupational therapists and their managers

College of Occupational Therapists

College of Occupational Therapists

First published in 2015
by the College of Occupational Therapists Ltd
106-114 Borough High Street
London SE1 1LB
www.cot.org.uk

Author: College of Occupational Therapists
Writer: Henny Pearmain
Category: Guidance

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN 978-1-905944-49-1

Typeset by Servis Filmsetting Ltd, Stockport, Cheshire
Digitally printed on demand in Great Britain by the Lavenham Press, Suffolk

Contents

Contents

1 Introduction

> *Regulation is no substitute for a culture of compassion, safe delegation and effective supervision. Putting people on a centrally held register does not guarantee public protection. Rather it is about employers, commissioners and providers ensuring they have the right processes in place to ensure they have the right staff with the right skills to deliver the right care in the right way to patients.*
>
> (DH 2013, section 5.22)

In the 2012 Mid Staffordshire NHS Foundation Trust Public Inquiry, poor supervision of medical and nursing staff was highlighted repeatedly. The government response to the Francis Enquiry recognised that 'the key to providing safe, effective and compassionate care to patients is supporting and valuing staff' (DH 2013, section 1.26). The support provided and the value demonstrated through supervision has a direct impact upon the quality, safety, appropriateness and effectiveness of service provision.

Recognising this, the College of Occupational Therapists (COT) has developed this guidance to enable practitioners and managers to set up healthy and effective supervision practices. It establishes that supervision is a requirement of quality standards and strategy documents across the four nations of the United Kingdom (UK). It also provides ideas and information that will be useful to those providing supervision and those receiving it.

1.1 What is supervision?

The definition of supervision has matured over time, taking on additional aspects or qualities, reflective of its context and purpose. Different qualifying adjectives are sometimes added, for example 'professional' or 'clinical' supervision, but it can be difficult to find one common acceptance, understanding or use of these.

At its simplest, supervision is a professional relationship and activity which ensures good standards of practice and encourages development.

An early World Health Organization publication defines supervision (as a managerial activity) as the 'overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work' (Flahault et al 1988, p1).

Ferguson defined professional supervision as 'a process between someone called a supervisor and another referred to as the supervisee. It is usually aimed at enhancing the helping effectiveness of the person supervised. It may include acquisition of practical skills, mastery of theoretical or technical knowledge, personal development at the client/therapist interface and professional development' (Ferguson 1989, in Rose and Best 2005, p294).

Morrison defined it as 'a process in which one worker is given responsibility by the organisation to work with another worker(s) in order to meet certain organisational, professional and personal objectives' (Morrison 2001, p29).

Howatson-Jones states that 'clinical supervision is a designated reflective exchange between two or more professionals in a safe and supportive environment which critically analyses practice through normative, formative and restorative means to promote and enhance the quality of care' (Howatson-Jones 2003, p38).

Skills for Care (2007, p5) defines supervision as 'an accountable process which supports, assures and develops the knowledge skills and values of an individual, group or team'.

Some common elements can be drawn from these definitions:

- Supervision involves a professional relationship.
- It is a process.
- It is active/dynamic, having objectives.
- It may involve a range of activities.
- It is supportive.
- It relates to standards, effectiveness and competence.
- It relates to the acquisition and development of knowledge, skills and values.
- It can incorporate personal, professional and organisational elements.
- It can be reflective when related to practice.

The content of supervision changes according to its context and the working relationship of those involved. Supervision enables the supervisee to develop professional, organisational and personal capabilities which promote and maintain the quality and effectiveness of their work. The end purpose almost always remains the same, being the promotion of the wellbeing and best interests of the service user, within a clinical, educational or any other context. The benefits are even wider, as the Social Care Institute for Excellence (SCIE) states:

> *Good supervision should result in positive outcomes for people who use services as well as similar outcomes for the worker, the supervisor and the organisation as a whole. An example of a positive outcome would be an improvement in the quality of life for a person, while for the organisation a similar outcome would be an improvement in the quality of the service.*
>
> (SCIE 2013, p6)

Table 1 shows how the kind of support/guidance provided, and the person providing it, will depend upon the context for, and function of, the supervisory relationship.

Table 1

Supervision for:	Covering:	Provided by:
Professional matters	– areas of work related to the occupational therapy profession, e.g. professional standards, registration, code of ethics, etc. Also continuing professional development (CPD) in occupational therapy-related areas.	– an experienced occupational therapist or someone with an adequate knowledge of the profession and its requirements.
Clinical work/ activity knowledge and skills	– the skills and knowledge needed to do the work confidently and safely, management of particular cases, service-user-related matters. Identifying solutions to problems, improving practice and increasing practice-related understanding and knowledge.	– a person/people with a higher level of knowledge and skills in the relevant area. This is most likely to be an occupational therapist but, depending on the area of work or particular activity, it may not be.
Organisation and management	– elements of work related to the organisation and management of the service; supporting the objectives of the organisation, ensuring the safe working of its staff, e.g. service policies and procedures, general training such as health and safety, annual leave, etc.	– a person who deals with the organisation and management of the service – not necessarily an occupational therapist.
Performance management	– the management and optimisation of elements of a person's performance.	– a person with a high level of ability in the relevant area of performance. Depending upon the area or activity involved, it may not be an occupational therapist. If across a number of elements, it may involve more than one person.
Tutor support in higher education institutes	– ensuring students have adequate knowledge and skills to meet the requirements of graduate entry to the profession.	– a tutor with adequate experience, competence and teaching skills in the relevant field.
Placement education	– enabling the students to gain knowledge, skills and experience to become fit for employment as a professional graduate.	– an occupational therapist with adequate experience and competence to provide this support. Input may also come from a range of other professionals, especially in a diverse practice placement.

Supervision for:	Covering:	Provided by:
Preceptorship or newly qualified graduates	– supporting a new registrant through their first year of practice, enabling the development of professional identity, facilitating access to clinical practice and knowledge.	– an occupational therapist with adequate experience and knowledge to provide this support (ideally a minimum of two years' practice).
Returning to practice	– enabling a returner to regain confidence, meeting any identified learning needs, experiencing and becoming familiar with the current working environment.	– an occupational therapist who has been registered continuously for the previous three years, without any fitness to practise concerns.
Peer support	– exploring cases, sharing experiences, studying published literature, using group discussion and shared knowledge to problem-solve, develop and provide support.	– through a group of similarly experienced occupational therapists.
Group support	– facilitating the learning of the group, helping members to observe, reflect, analyse and plan. Using group discussion and shared knowledge to problem-solve, develop and provide support.	– (facilitated by) an experienced practitioner who is skilled at managing group dynamics. This will need to be an occupational therapist if the focus of the group is profession-specific.

1.2 Professional and clinical supervision

Professional supervision and clinical supervision inevitably cross over in many circumstances and may well be supplied by the same person. Both enable the supervisee to underpin and root their practice in a sound understanding of the core values, beliefs, knowledge and skills fundamental to occupational therapy. The material in this guidance can be applied to most supervision contexts, although it will relate most clearly to professional and clinical supervision.

Such supervision may be done in a number of ways according to the function it is fulfilling at the time. To take time to reflect and discuss, a one-to-one 'sit down' meeting may be used. To demonstrate an activity, observe a particular situation or oversee the supervisee carrying out an activity, more practical 'on the go' supervision may occur. Both provide support, allow reflection and learning, develop skills and knowledge and promote good practice.

1.3 Theoretical models for supervision

Models are a way to organise and thereby structure an approach to supervision. Use of a model can facilitate interaction and ensure continuity. There are a number of models for supervision. Practitioners are advised to research a number of them and select one that would fit comfortably within their particular workplace and organisation. There may already be a chosen model in place locally.

Proctor proposed a conceptual framework for clinical supervision which is often referred to in later papers and publications. It is sometimes called the Functional Interactive Model. It identified three main functions: normative, formative and restorative (Proctor 1987). It could also be applied to professional and management-type supervision:

Normative – this is the enabling of the supervisee to reflect on the quality, effectiveness and appropriateness of their practice. Although the supervisor retains ultimate responsibility for ensuring that the supervisee's work meets all the legal, ethical and professional requirements or 'norms' of practice, they are also developing the supervisee's own awareness and sense of responsibility.

Formative – this is the 'formation' of knowledge, skills and attitudes/behaviours. The supervisor uses a range of means (facilitation, feedback, instruction and demonstration), enabling the supervisee to develop their competence.

Restorative – this is the provision of support and affirmation, enabling the supervisee to cope with the emotional aspects of practice.

Each function will at times be more evident than others, but they frequently cross over and supervision becomes a mixture of all three.

Nicklin's Clinical Model of Supervision focuses on the roles and functions of the organisation (managerial, education and support) working together, where a change in one will impact on the others. The model presents supervision as a cyclical process of analysis, problem identification, objective-setting, planning, action and evaluation (Nicklin 1997).

1.4 Reflective practice

Reflective practice goes hand in hand with supervision. It means:

taking the time and conserving the energy to think critically about your practice. It means stepping outside the action in order to see how to improve what takes place. You can then assess and plan what you need to learn in order to develop and improve your practice.

(COT 2010a, p6)

Finlay (2008) states that reflective practice:

tends to involve the individual practitioner in being self-aware and critically evaluating their own responses to practice situations. The point is to recapture practice experiences and mull them over critically in order to gain new understandings and so improve future practice. This is understood as part of the process of life-long learning.

(Finlay 2008, p1)

A very simple reflective model is a cycle of three questions – 'what?', 'so what?' and 'now what?'

It is usually attributed to Borton (1970) as a model for learning, and continues to be used (Rolfe et al 2001). The questions direct the practitioner through a reflective cycle of describing the experience, analysing and evaluating the experience and

finally looking at how the experience can be used to change and improve future practice.

These questions are prompts to encourage reflection and discussion, either when carrying out an activity with a service user, or when later talking about it. It is a useful tool for the supervisor to challenge the views or actions of the supervisee, enabling them to adjust their own perception or understanding of a situation and thereby change their actions. The supervisee can use the model as a pattern for independent reflection and a structure for recording learning, where needed.

Developing a reflective approach to practice and learning can help practitioners record and demonstrate how they are meeting the continuing professional development requirements of the Health and Care Professions Council (HCPC).

1.5 Evidence-based practice

Practitioners are expected to base their intervention on evidence, best practice and/or local/national guidelines and protocols where available and appropriate (COT 2011b, section 4.6, COT In press, section 2.2.5). This requires an awareness of the evidence available and the ability to review and then apply it. It can be difficult to do this within the business of the working day. Supervision provides protected time in which 'it may be possible to move from a change in knowledge to a change in practice' (Steventon et al 2012).

2 Providing supervision

2.1 Supervision policies

An organisation's or service's policy should define its approach to and rationale for supervision. It should define the aims and functions of supervision within the context of that particular work setting. It should explain how supervisors are selected and trained, what their rights and responsibilities are, and those of the supervisee, including confidentiality. It might include a recommended structure and model, frequency, system of recording and a model agreement for supervision. Supervision policies may cross over significantly with supervision agreements. If no such policy exists within an organisation, it may be an opportunity for an occupational therapist to propose one, but it should not stop practitioners from using or seeking supervision.

2.2 Ways or structures to provide supervision

There are various ways to provide supervision. The choice of approach will depend upon a number of factors, including the nature of the support required, personal preference, access to a supervisor, the experience and skills of those involved, local organisational policy and commitment, and the degree of management/organisational support:

- One-to-one supervision is the structure that most practitioners are familiar with. The supervision may be a mixture of working together, working under direction, being observed working and also having regular 'sit down' meetings together.
- Peer supervision is different in that it is not led by a more senior practitioner. When formal, its members are committed to meeting regularly. It can be occupational therapy specific, or across professions. Peer support can be an opportunity for the sharing of resources, knowledge, skills and ideas. It can also be less formal, with support and sharing across a group or team as needed.
- Group supervision is when a more senior practitioner meets with and facilitates a group for specific problem-solving and team development. This approach not only encourages open and professional attitudes to learning and uses the various abilities within the group, but also supports the concept of collective practice and service delivery. It requires a planned approach and places a shared responsibility on all members of the group to support the learning of colleagues, helping them to observe, reflect, analyse and plan. The supervisor tends to take a role in managing the group dynamics. Those participating in group supervision will need to be well prepared and clear as to what they want to give to, or receive from, the group. Using a reflective practice model can help to structure discussions.
- Long-arm supervision is when supervision is provided by an experienced clinician who is not based at the same location. Support and advice are provided through a mix of face-to-face meetings and distance communication, via the telephone, Skype, email, or other means depending on the supervisee's preferences. It is most likely to be used where the practitioner is the only occupational therapist within a service or locality. This is increasingly happening with the growth of diverse practice and diverse placements for students.

In this situation, there should be a line of management or responsibility on site also, providing local and immediate support, although this local manager need not be an occupational therapist. The nature and content of both the long-arm and local supervision should be discussed and formally agreed between all parties involved. The long-arm supervisor and the practitioner should work within an agreement, as with any other supervision.

More information about supervision for students who are on diverse (role-emerging) placements is available from *Developing the occupational therapy profession: providing new work-based learning opportunities for students* (COT 2006a, p9).

2.3 The participants

The focus for a supervisor is on supporting staff in their personal and professional development and in reflecting on their practice. The kind of supervision needed by each practitioner will be dependent upon the role that they hold and their level of experience.

In a number of papers regarding supervision, the importance of adequate training and knowledge of models of supervision is mentioned in relation to making supervision effective (Sweeney et al 2001, Gaitskell and Morley 2008). This is not exclusive to supervisors but includes supervisees. Also highlighted is the confidence needed by supervisors to make positive use of more directive and challenging interaction. The supervisor needs to have effective supervisory strategies, a 'toolbox' of techniques and skills to use, in order to enable the personal and professional development of the supervisee. It is suggested that occupational therapy managers have a responsibility to consider how effective supervision skills are developed and maintained in the workplace (Gaitskell and Morley 2008, p120).

For personal study, there are numerous publications which describe in detail the techniques and skills necessary for a supervisor. For this reason they are not included here. The *Preceptorship handbook for occupational therapists* (Morley 2012) also highlights a number of these.

The supervisee is not a passive participant in the supervision process. In order for it to be effective, the supervisee needs to be an active learner, seeking and utilising the support and learning opportunities available. The use of a structured learning plan, with clear objectives, may help the supervisee to optimise the process, much as is used in the preceptorship programme (see sections 2.8 and 3.4).

2.4 Supervision and delegation

When in a supervisory or leadership role, a practitioner needs to be aware of their responsibilities in relation to delegation. When the delegator asks or instructs another person to carry out interventions or other procedures, they should be satisfied that the person to whom they are delegating is competent to do so. In these circumstances the delegating occupational therapist retains responsibility for the occupational therapy care provided to the service user (adapted from section 5.2 of the *Code of ethics and professional conduct* (COT In press).

The *Professional standards for occupational therapy practice* (COT 2011b) state:

5.5 You ensure that those to whom tasks or actions are delegated – such as students, support workers and volunteers – are competent to carry them out

Criteria

5.5.1 You provide adequate information, supervision and training to other members of staff, volunteers and carers if they are to provide intervention

5.5.2 You monitor the competence of those to whom you delegate tasks

5.5.3 You do not ask other staff to carry out tasks that are outside their professional competence, terms of employment or workload capacity.

(COT 2011b, section 5)

This is supported in section 5 of the COT *Code of ethics and professional conduct*, which also adds:

You should provide appropriate supervision for the individual to whom you have delegated the responsibility.

(COT In press, section 5.2.1)

The supervisor/delegator will need to judge the level of supervision that is provided while the person is carrying out the task, depending on their ability and level of experience. It is the delegator's responsibility to monitor the activity and its outcomes. This includes ensuring that care records are fully and accurately kept.

The Health and Care Professions Council (HCPC) lays particular emphasis on the importance of supervising those to whom tasks are delegated. Its *Standards of performance, conduct and ethics* (HCPC 2012) states:

You must effectively supervise tasks you have asked other people to carry out. People who receive care or services from you are entitled to assume that you have the appropriate knowledge and skills to provide them safely and effectively. Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills and experience to carry out the tasks safely and effectively. You must not ask them to do work which is outside their scope of practice.

You must always continue to give appropriate supervision to whoever you ask to carry out a task. You will still be responsible for the appropriateness of the decision to delegate. If someone tells you that they are unwilling to carry out a task because they do not think they are capable of doing so safely or effectively, you must not force them to carry out the task anyway.

(HCPC 2012, section 8)

You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

(HCPC 2012, section 10)

Further information is available from the most recent version of the COT briefing on *Delegation* (COT 2014a), available for members to download from the College website.

When an occupational therapist is line managed or supervised by someone from another profession, or an occupational therapist line manages/supervises someone from another profession, the manager needs to be aware that they are still responsible for

ensuring that the practitioner is competent to carry out any tasks (whether clinical or otherwise) that they delegate to them.

Occupational therapists must act within the limits of their knowledge, skills and experience (COT In press, section 5.1, HCPC 2012, p3). When a supervisee recognises that any task is above their capability level, they must highlight this and seek help from the supervisor.

2.5 The supervisory relationship

The nature of the supervisory relationship is key to its effectiveness. It should be supportive and enabling, building confidence and reducing stress. It also needs to balance support with challenge, so that, when necessary, it can be directive. It must be accommodating enough to allow each participant to provide comment, opinion and feedback to the other without a negative outcome. Supervision should provide a straightforward means for constructive two-way communication.

In a supervisory relationship, both or all parties play an active role in making it healthy. Perhaps some of the more obvious characteristics of such a relationship are trust and honesty, listening, empathy, acceptance and respect. Cassedy (2010) looks at this in some detail. The supervisor, being in a leadership or more senior role, needs to initiate and model these qualities.

A supervisor has the responsibility to identify poor practice to the supervisee, but to do this in a way that enables them to change without losing confidence. Likewise, if a supervisee finds something difficult, if they are struggling with their work, with an element of supervision, or with the supervisory relationship, the supervisor should enable them to share this, to explore their difficulty, and then to make whatever changes are necessary and possible. To enable this, both the supervisor and the supervisee need to take responsibility for their part of the supervisory relationship.

Sometimes it can be difficult for the supervisor or supervisee to empathise with, accept and respect an individual who seems very different from themselves. In such a situation it can be useful to draw on professional skills. When working with a service user, irrespective of their nature or behaviour, a practitioner would be expected to act professionally at all times. This ability can be transferred into a difficult supervisee/ supervisor relationship.

When a relationship goes wrong, it may be useful to involve a third party. This person needs to be skilled in mediation. They may need enough authority or confidence to make recommendations if required. Each person will need to reflect on the situation, to identify what they see as the difficulty, to suggest resolutions, to be open to accepting criticism and potentially to accept compromise. It is important that each party is heard and believes they have been treated reasonably. It is likely that some changes will need to be made. The situation will need to be monitored and revisited for as long as necessary to ensure that it is resolved to the satisfaction of all concerned.

Where the relationship seems irreparable, it may be necessary to change the supervisor. In this case the new supervisor will need to understand the history of the situation to be able to provide appropriate ongoing support. Both parties in the original relationship will need to be encouraged to move forward in a professional manner.

2.6 Starting supervision

Before supervision begins, there are a number of elements that need to be discussed and agreed, in order to obtain the best outcomes for those involved.

Each party needs to understand the purpose, function and content of supervision. Where a supervisee has more than one line of responsibility, it is especially important to clarify this.

The content of supervision will depend upon its context and purpose. It may also reflect the competence and confidence of the supervisee and supervisor. The participants may need to define what should or should not be included in supervision. Proctor's model can be used as a guide. If potential content cannot be fitted into any of the normative, formative and restorative elements of supervision, it may be that it is not appropriate (see section 1.3).

Where appropriate, the use of an agreement or contract can help in this discussion. It is good practice to ensure that each person understands and accepts their responsibilities in making supervision effective.

The working relationship, the degree of direction given, the level of hands-on supervision, the styles of communication used, the supervisee's best learning style etc. all need to be discussed, as these will be different in each supervisory relationship. What works in one situation may not work in another. With open communication and a constructive feedback system, changes can be made over time, recognising that the supervisee's needs may also change as they grow in capability and confidence.

2.7 Supervision agreements

Supervision agreements or contracts are not always used, but they can be a very useful tool to support the structure and quality of supervision. The use of the term 'agreement' rather than 'contract' emphasises the collaborative nature of the process (SCIE 2013). The use of a written agreement has been described as 'an essential component of professional supervision. It constitutes a working agreement between the two parties who are the supervisor and the supervisee.... It will monitor the progress and success of supervision and can parallel the process of therapy' (Rose and Best 2005, p295). Supervision agreements should always be set within the context of the local supervision policy, where one exists.

Learning agreements for students are a requirement of the *College of Occupational Therapists' learning and development standards for pre-registration education* (COT 2014b, p19).

One aim of the agreement is to clarify the duties and expectations on both sides. It emphasises that supervision is a dual responsibility. The presence of an agreement can add security, creating a safe and secure supervisory relationship in which those involved can review the individual's practice, work through problems or concerns and discuss professional development needs. Each person involved should have a copy of the agreement.

When drawing up a supervision agreement, the following should be considered and could be included:

- Who the agreement is between.
- Who holds copies of the agreement.
- When the agreement will be reviewed.
- The types of supervision that might be used; for example, hands-on demonstration or close overseeing of a task, one-to-one meetings, group meetings and so on.
- What model might be used.
- The frequency and length of supervision events/meetings.
- The location for supervision events/meetings.
- Who takes responsibility for organising the supervision events/meetings.
- In what limited circumstances supervision might be cancelled.
- The content of supervision, what may or may not be brought to a supervision event/meeting by either party, also how much material may be brought.
- What each party might need to prepare prior to any event/meeting.
- Who will record formal supervision, and how.
- How records will be kept.
- What will happen to the record if the supervisee leaves, changes job or has a different supervisor.
- The extent of confidentiality and when or how it might/should be broken.
- What the supervisee can expect or have a right to.
- What the supervisor can expect or have a right to.
- What the supervisee's responsibilities are.
- What the supervisor's responsibilities are.
- How conflict, or the inability to maintain the agreement, will be managed and resolved.
- Reference to a local supervision policy if present.

Agreements can be quite formal and business-like or written in a more personal style. There are a number of differing templates for supervision agreements available on the internet. The style and content of any agreement need to be adapted for use in the particular location and with those involved, to suit the needs and working relationship of all parties.

The agreement should be reviewed periodically as part of an evaluation of the supervision. Do those involved in the supervision process adhere to the agreement? If not, is this a problem with the supervision, or the agreement itself? Does the agreement support the supervision process, or hinder it? There is nothing wrong with amending a supervision agreement, post review, so long as any changes are to enhance the supervision process, experience and outcomes.

2.8 Setting objectives for and in supervision

The effectiveness of supervision in itself needs to be monitored. To do this it is necessary to identify what it should be achieving or providing to all participants. Different kinds of supervision will have different objectives, but these should be identifiable. Consideration needs to be given as to how they could be monitored or measured.

A key purpose of supervision is to enable the supervisee to develop their personal, professional and organisational knowledge and capabilities. In order to monitor the development of the individual and to give structure to their learning, it is important to set objectives. These might be relatively concrete, such as gaining a new skill or increasing knowledge. They might be less tangible, such as gaining in confidence or changing attitude or behaviour. It is important that the supervisee agrees with and takes responsibility for their part in meeting these objectives (see section 2.3).

2.9 Content and confidentiality

The content of a supervision meeting/event and how the time will be used should be discussed as part of the agreement. The degree to which personal issues are included needs to be considered. They are usually only included when they have implications for the workplace, for example the supervisee's health.

Information that is shared within supervision must be kept confidential, except where it is revealed that a person or persons may be at risk. Instances that might override the need for confidentiality might include revelation of dangerous practice or criminal activity (i.e. when it is in the public interest to share the information). Information should only be shared on a strictly need-to-know basis. If the supervision involves an element of performance management, this need only be shared with those who are involved in monitoring performance. It is not a matter for general discussion.

The supervisee should be able to discuss with other colleagues appropriate content from supervision as a means of further reflection. For example, if the supervisor makes a suggestion for how to manage a practice situation, the supervisee may then talk this through with another colleague.

If the supervisor finds that they are unable to answer a particular problem or situation raised by the supervisee, consent should be gained from the supervisee to discuss the situation with a more senior/experienced colleague.

2.10 Frequency and timing of supervision meetings

There is no set standard or recommendation for the frequency of formal supervision sessions within occupational therapy. It will vary according to individual requirements, but needs to be guided by the experience, competence and confidence of the supervisee, along with the complexity and demands of their role. Students and less experienced practitioners can expect to receive more frequent supervision. Those who demonstrate poor performance will also need greater support. Whatever frequency is decided upon, supervision should happen regularly and consistently.

The College cannot define a minimum requirement for supervision, as every individual and location will be different. The following could be used as a starting point for consideration or negotiation:

- Weekly supervision for those who require more support, even for a limited or initial period:
  - Students
  - New graduates
  - New employees with limited experience
  - Practitioners lacking in skills and/or confidence.
- Bi-weekly supervision for those who have more experience and work more autonomously but may still need guidance:
  - Those new to their grade – i.e. with additional/unfamiliar responsibilities
  - New employees with experience
  - Employees with a complex or high-risk caseload.
- Monthly supervision for:
  - Experienced and confident practitioners.

The agreed time set aside for supervision should be protected by both parties. We would suggest that supervision time is at least an hour and sufficient to cover all necessary topics. It should not be delayed or cancelled, if at all possible. It should start and finish at the prearranged times and should not be interrupted while happening (either by phone calls or individuals). Ideally the meeting should be conducted in a quiet, private room with the door closed.

2.11 Recording supervision

As with care records, recording supervision enables safe, effective and high-quality practice.

It can be decided, as part of the agreement, who records the supervision, how the content of records is agreed and how the records are kept. Formalising the process in this way protects both parties from any future perceived differences (by either party) of the discussion points and/or decisions made. A formal structure can be seen as threatening if it has been introduced in negative circumstances, but if used as a matter of course with all staff members, this need not be the case. It is likely to make the task of keeping records easier and less time-consuming in the long run.

The records should include key topics discussed, with any outcomes or decisions taken, identifying who is responsible for any future action. The record, when complete, should be agreed by both parties and a copy may be held by each person. Supervision records need to be kept confidential, with the proviso that if access is needed for the purpose of public interest, this should be enabled.

Decisions made in a supervision meeting concerning the care provided to a service user can be seen as part of the care process. Such decisions need to be recorded in the care records (COT 2010b, section 2.2). Identifiable service user information should not be recorded within supervision records. If cases are discussed, these need to be anonymised in any supervision record.

2.12 Feedback for both parties

> *Feedback is a way of learning more about ourselves and the effect our behaviour has on others. Constructive feedback increases self-awareness, offers guidance and encourages development, so it is important to learn both to give it and to receive it. Constructive feedback does not mean only giving positive feedback (praise). Negative, or critical feedback given skilfully can be very important and useful. Destructive feedback, negative feedback given in an unskilled way generally leaves the recipient simply feeling bad with seemingly nothing on which to build and no useful information to use for learning.*
>
> (University of Nottingham 2012)

Two-way feedback is an important part of successful supervision. The supervisor needs to provide feedback to the supervisee on their performance as a practitioner and as a participant in the supervision process. In a practice setting, working with service users, there needs to be a rationale for all the practitioner's actions. Providing feedback, reflecting on and looking at the consequences of actions all help the supervisee to develop the habit of identifying the rationale for their practice and ensuring it is the best option.

The supervisee also needs to give feedback on the style, content and effectiveness of the supervision provided. Regular evaluation of the supervision process and experience itself is essential to ensure that the aims of the process are met and that any difficulties are discussed. The giving and receiving of constructive feedback on a regular basis can help to improve the experience and outcomes of supervision for both the supervisee and the supervisor. The supervisor can use those feedback experiences as development content for their own supervision.

If the supervision is not meeting the needs of the supervisee, or the aims of the process are not being met, those involved may need to look more closely at the different elements of the practical process, along with the working and supervisory relationship, to identify what needs to change in order to make the process work.

Feedback should be open and honest, but should not need to feel threatening. Time set aside at the start of the process for discussing and planning the supervision, identifying its purpose and objectives, and developing the supervision contract, can pay dividends if the agreed factors are used as a structure against which to monitor and feed back on its effectiveness.

Regular feedback ensures that the supervision process can be tailored to meet the needs of both parties; potential problems can be dealt with at an early stage, preventing unwelcome surprises.

There are some common techniques that occur when constructive feedback is described:

- Consider the purpose of the feedback so that it is focused and has a positive outcome.
- Always balance any negative feedback with positive, and start with the positive.
- Be specific about what has been observed and do not be judgemental. Focus on the activity, not the person.
- Find out what the individual was attempting to achieve.
- Describe the actual impact or consequence of the person's actions.

- Discuss/offer alternatives.
- Give time for the individual to respond/feed back.
- Stress the support available.

2.13 Supervising a person with additional needs

Occupational therapists are experts in analysing activity, assessing needs and adapting tasks and/or environments to enable a person to function as well as possible. These skills may be needed when working with and supervising colleagues who have additional needs, such as dyslexia, depression, a hearing deficit or long-term condition. A practitioner or student with additional needs may find work more of a challenge than their peers; for example, they may have difficulties with concentration, communication, organisational skills, periods of ill health and so on. This is unlikely to be resolved by performance management processes, as the underlying difficulty is not being recognised and accommodated.

The Equality Act 2010 requires employers to be flexible and to make 'reasonable adjustments' for people with disabilities to enable them to do their jobs. These adjustments need not always be in relation to the environment or particular equipment, but may need amendments to practice processes, communication methods, time management and so on.

It is vital that, if the supervisee has additional requirements, these are shared and discussed. It does not help to hide or lessen the extent of any difficulties. The supervisor needs to create a relationship that supports disclosure and discussion. This can increase the supervisor's understanding of a condition and how it affects the individual's function, enabling any support required to be tailored to the person's needs. Preferred learning styles should be taken into account with students and practitioners. Solutions to difficulties may be simple and very practical. For example, for someone with dyslexia it may help to have a clock clearly visible, represent required processes diagrammatically (flow diagrams) and provide a quiet space for those who find the noise of a busy office difficult to cope with. Help with moving and handling from a therapy assistant can enable a practitioner with musculoskeletal limitations to fulfil their work obligations.

Most people who have additional needs will understand and can explain their own requirements, especially if they have developed a solution in a previous place of work. It may be the supervisor's responsibility to facilitate these requirements and explain them to other members of staff. The culture and atmosphere of the department needs to be one where asking for help is easy.

If a supervisor or placement educator thinks that the supervisee's/student's impairments are causing difficulty, these concerns should be broached as soon as possible. If a student or inexperienced practitioner is not familiar with how their impairment affects them in a particular setting, an opportunity should be made to work collaboratively to analyse and resolve any possible difficulties.

The practitioner/student, supervisor or service manager may need to work with the local human resources and occupational health departments to find the best way to support the individual, especially if their condition fluctuates. A period of rest during the day, time off to recover from an acute episode, or flexible working arrangements may all need to be considered. A workplace needs assessment may enable the service and the individual to access further support and training.

2.14 Training for supervision

As with other skills, supervision needs to be learnt: 'just as an unqualified individual would not be expected to provide therapy, neither should an unqualified and inexperienced individual be expected to supervise novice clinicians' (Stoltenberg and Delworth 1987 cited in Sweeney et al 2001, p428). Sweeney et al emphasised the importance of appropriate training for both supervisors and supervisees (Sweeney et al 2001, p428).

The *Northern Ireland allied health professions (AHP) supervision policy* (DHSSPS 2013) recognises the need for training in supervision skills, for both supervisors and supervisees. Other local training exists in various places in the UK, but, apart from the scheme described below, there is no other nation-wide recognition of the need for, or provision of, supervision skills training within occupational therapy.

The College of Occupational Therapists introduced the Accreditation of Practice Placement Educators' Scheme (APPLE) in September 2005. This is under licence from the Chartered Society of Physiotherapy (CSP) and has adopted six learning outcomes from the CSP's Accreditation of Clinical Educators (ACE) Scheme.

APPLE is a national scheme for qualified occupational therapists and other health and social care professionals involved in the education of occupational therapy students. While not compulsory, it provides an opportunity for professional recognition of the role of practice placement educators and nationally standardises the varying practices of accrediting educators, as well as providing a means of monitoring and evaluating the numbers of educators in different areas of the UK. This framework of learning outcomes can be recognised as a training opportunity with transferable skills for supervision of junior staff as well as students.

More information and all relevant documents are available on the website of the College of Occupational Therapists: http://www.cot.co.uk (Accessed on 02.10.14).

3 Supervision within the context of other means of development

3.1 Supervision and annual appraisal

The annual appraisal provides an opportunity for practitioners to reflect over the previous year and then consider what knowledge, skills and experiences they require in order to maintain their competency, further develop their work and contribute towards meeting the larger organisation's objectives.

Identified learning objectives may be considered and dealt with in supervision, depending upon their nature. Supervision provides an opportunity to monitor if these objectives are being met. The supervisor may need to provide guidance or encouragement to assist the supervisee in seeking out appropriate learning opportunities.

3.2 Mentoring and coaching

These are both specific techniques which may be used to provide support to a practitioner, either as part of supervision or as stand-alone activities. Choice of their use would be dictated by the needs, preferences and development style of the practitioner. Although many of the terms used to describe these supporting activities are sometimes used interchangeably, the College sees them as different kinds of relationship using different approaches, with differing outcomes.

The College has an *Occasional paper on mentorship* (COT 2010c) which seeks to explain how mentorship can support the professional growth and development of occupational therapists throughout their careers. It is seen as quite a formal relationship where 'mentor and mentee work together to discover and develop the knowledge and skills needed by the mentee to grow' (McKinley 2005, p34 in COT 2010c, p6). The mentor 'shares her or his expertise and provides appropriate support, guidance and encouragement to facilitate the mentee's professional development' (COT 2010c, p8).

Coaching is usually more structured and specific, focusing on the development of a specific skill/skill set or understanding. Coaching can be directive or non-directive; either style aims to enable the individual to learn. Directive coaching may provide specific instruction, whereas non-directive coaching would use more open reflective questions.

3.3 Performance management

Performance may be seen as the manner in which something or somebody functions, operates, or behaves; or the way in which somebody does a job, judged by its effectiveness.

For the purpose of occupational therapy, good performance could be seen as carrying out work that is appropriate and effective; that meets professional, organisational, local and national quality standards and performance targets; and that provides the service user with a positive experience.

> *Effective practice is achieved when an action, intervention or system does what it is intended to do. If it is effective, the practice will bring about the desired result or outcome.*
>
> (COT 2013)

The role of a supervisor always has an element of performance management. The supervisor's aim is to optimise the performance of the supervisee, as defined above. This may be from any starting point along the continuum of poor to excellent practice.

In a situation where there is poor practice, the supervisor may need to work more specifically to enable the supervisee to recognise the poor performance, to set very clear achievement targets, and to develop the skills that are required. To ensure this is effective, the supervisee needs to be engaged and motivated to learn and improve.

Depending on how best an individual learns, the supervisee may need a period of more directive supervision, but this needs to be positive support, enabling them to reflect and learn. The use of continuous monitoring or observation can have very negative effects upon the supervisee. It quickly reduces their confidence, raises their level of stress and may reduce their motivation and performance. It is not something that should be frequently used unless the supervisee is deemed as being unable to work safely and there is a recognised risk to service users without direct supervision.

3.4 Preceptorship

Preceptorship has been defined as:

> *a structured development process, including observed practice and feedback against agreed standards, to support newly qualified practitioners to build their professional identity and competence in order to facilitate their successful adaptation into the workplace.*
>
> (Morley 2007)

It is recognised that making the transition between student and qualified practitioner can be challenging:

> *Although they are competent, knowledgeable and registered to practise, new OTs still need the support and guidance of experienced professional colleagues as they find their feet in professional practice.*
>
> (Morley 2012, p5)

The occupational therapy preceptorship programme provides a structure and process by which to help new graduates to do this. Information to support its use is available in the *Preceptorship handbook for occupational therapists* (Morley 2012).

The programme is very transferable, with some modification, to other non-NHS, local authority, independent and voluntary organisations. Along with new graduates, it can be used with returners to the profession and those who have trained abroad. It provides a structured way to update and ensure adequate professional skills and knowledge.

The new graduate/returner (preceptee) is provided with a preceptor who is a 'qualified occupational therapist, ideally with a minimum of two years' post-graduate experience

and with knowledge of the preceptee's area of work. Usually this is the preceptee's clinical supervisor' (Morley 2012, p12). Thus the skills of a supervisor can be extended into preceptorship.

In England, preceptorship was formally recognised for the allied health professions in the *Preceptorship framework for newly registered nurses, midwives and allied health professionals* (DH 2010). This was designed for the NHS in England and is linked to the Knowledge and Skills Framework for the NHS.

> *The DH framework states that preceptors need to act as exemplary role models, having insight and empathy with the new practitioner. They have a number of responsibilities, including sharing their knowledge and skills and providing feedback, and developing others professionally to achieve their potential. It also recognises that preceptees need to take responsibility for their own learning and development, accessing support and reflecting on their practice, in order to develop their professional knowledge, skills and values.*
>
> (Adapted from DH 2010, p13)

In Scotland, the Flying Start NHS programme for newly qualified nurses, midwives and allied health professionals aims to support their learning and build their confidence during their first year of practice in NHSScotland. The information is all available online. Support is provided by workplace mentors. See http://www.flyingstart.scot.nhs.uk (Accessed on 04.09.2014).

Welsh health boards have local nursing preceptorship programmes in place linked to the DH 2010 framework and the *Nursing and Midwifery Council preceptorship guidelines* (NMC 2006).

Although Northern Ireland has a published framework, the *Preceptorship framework for nursing, midwifery and specialist community public health nursing in Northern Ireland* (NIPEC 2013), it does not incorporate the allied health professions.

4 What if there is no supervision available?

4.1 Putting together a proposal

As with any new development in a service, the best way of obtaining organisational and possible financial support for supervision will be to put forward a proposal. This will need to demonstrate the requirements for, and benefits of, supervision.

While supervision is to the benefit of the practitioner, any proposal for the provision of supervision needs to highlight the requirements for supervision and demonstrate its benefits to the organisation and the service user. Each service provider wants to provide safe and effective service and to meet its regulatory or quality standards. Supervision is integral to ensuring that practitioners and the services they provide meet the current national standards.

The introduction to this guidance identifies some of the key purposes of supervision and the benefits. The following may also be considered when developing a proposal:

- Benefits to the organisation:
    - Meeting governance requirements
    - Better risk management/decreased likelihood of incidents
    - Better recruitment and retention
    - Better quality of service provided
    - Better outcomes of care.
- Benefits to the service user:
    - High standards of care
    - Best/evidence-based practice
    - Safer care
    - Better outcomes of care.
- Benefits to the individual:
    - Support and guidance
    - Assured development and continuing professional development (CPD)
    - Better job satisfaction.

Section 4.3 identifies a number of key documents from across the UK that support the provision of supervision. They can be used to put together a convincing proposal for the provision of supervision where it does not currently exist.

4.2 Alternative ways to access supervision

In increasingly varied but pressurised working environments there is even greater necessity for support to ensure the safety and wellbeing of both service users and practitioners. If staffing structures are becoming increasingly flat, there will be fewer senior and experienced staff who can provide professional and/or clinical supervision. Where traditional 1:1 supervision is not locally available or not possible, practitioners need to think about alternative ways of fulfilling the functions that traditional 1:1 supervision would have achieved; for example, through peer supervision (see section 2.2).

It may be possible to negotiate periodic access to a more senior or experienced occupational therapist from outside the immediate department or organisation. If there is no one available in neighbouring statutory services, an independent practitioner could be approached. Most of these arrangements will need to be agreed formally and may have financial implications.

It may be possible to make best and most efficient use of an external supervisor through the use of group supervision, phone contact or an internet-based system.

If an occupational therapist is working alone, with no support, there may be increased risk of poor or unsafe practice, particularly if they are less experienced. Practitioners should always work within their professional competence, only providing services and using techniques for which they are qualified by education, training and/or experience (COT In press, section 5.1). Isolated occupational therapists need to have access to support in some way. It may be possible to link in to another local service, or to arrange for support from an independent practitioner, as above. Again, this may incur costs for the employing organisation. If requested, the COT Consultancy Service can usually organise the provision of external supervision by a suitably qualified and experienced occupational therapist.

4.3 Documentation in support of supervision

The requirement for supervision is written into legislation, standards and strategic documents across the UK:

- The Health and Safety at Work Act 1974 enacts a general duty on every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of all its employees, as well as environmental safety. The duty extends in particular to:

  > *The provision of such information, instruction, training and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of its employees.*
  >
  > (Great Britain. Parliament 1974, section 2c)

- The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. During 2014, the CQC carried out a number of consultations around changes in the way it regulates health and adult social care services.
- New regulations, the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (Great Britain. Parliament 2014), have been introduced, setting out fundamental standards of quality and safety. From April 2015 the new

regulations and guidance will replace, in its entirety, the *Guidance about compliance: Essential standards of quality and safety* (CQC 2010) and the 28 'outcomes' that it contains.

- The new fundamental standards have a number of requirements for employment and staffing:

  Staffing

  13. (1) The registered person [individual, partnership or organisation] must deploy sufficient numbers of suitably qualified, skilled and experienced staff in order to meet the requirements of this Part.

  (2) The registered person must ensure that persons employed by the registered provider in the provision of a regulated activity –

  (a) receive appropriate support, training, professional development, supervision and appraisal;

  (Great Britain. Parliament 2014, Part 2, section 13)

- The NHSScotland Framework for role development in the allied health professions states:

  Local staff governance and clinical governance systems must have mechanisms in place to ensure role development opportunities are appropriate for the specific professions, and that individual AHPs receive the preparation and ongoing supervision and support they require.

  (Scottish Executive 2005, p15)

- In 2013, the Scottish Government consulted on a consensus statement for allied health professionals, with regard to quality service values. The final statement now published states:

  Allied Health Professionals will have access to support from profession specific professional and clinical leadership and supervision on a regular basis to support professional development planning and clinical practice and will be provided with opportunities for continuing professional development which meets HCPC (Health and Care Professions Council) registrant and professional body requirements.

  (Scottish Government et al 2013)

- The 2012–2017 strategy for allied health professions in Northern Ireland recognises that:

  Appropriate and effective supervision and support, together with clarity of roles and responsibilities, can provide a structured framework to support good governance.

  (DHSSPS 2012, p36)

- It requires organisations to:

  ensure that appropriate induction, perceptorship [sic] and supervision are in place to support transitions along the career pathway.

  (DHSSPS 2012, p53)

- In 2013, the Department of Health, Social Services and Public Safety published the *Regional supervision policy for allied health professionals*. This

  > *sets policy direction for AHP staff, their professional leads and line managers to ensure processes and systems are in place to support professional supervision.*
  >
  > (DHSSPS 2013, p8).

- *Doing well, doing better: standards for health services in Wales*, published in 2010, is broader, including more detailed elements of care provision which recognise and address the needs of patients, service users and their carers, providing them with safe, effective treatment and care.

  > *They require service providers to ensure that their workforce are supervised and supported in the delivery of their role.*
  >
  > (NHS Wales 2010, Section 25, e)

Along with the requirements laid on the organisation, practitioners themselves are also expected to meet certain standards:

- The College of Occupational Therapists has responsibility for the promotion of good practice and the prevention of malpractice. The College of Occupational Therapists' *Code of ethics and professional conduct* states that:

  > *You should be supported in your practice and development through regular professional supervision within an agreed structure or model. Sole practitioners should seek out professional support and advice for themselves.*
  >
  > (COT In press, section 5.3.2)

The *Professional standards for occupational therapy practice* (COT 2011b) requires practitioners to 'receive regular professional supervision or support within an agreed structure or model' (COT 2011, section 5.3.6).

- The Health and Care Professions Council (HCPC) is the professional regulator. Its key function is to protect the public, setting standards for the training, professional skills, behaviour and health of the registrants. It requires registrants to

  > *understand the importance of participation in training, supervision and mentoring*
  >
  > and
  >
  > *recognise the value of case conferences, supervision and other methods of reflecting on and reviewing practice*
  >
  > (HCPC 2013, sections 4.6 and 11.2).

- The HCPC also lays particular emphasis on the importance of supervising those to whom tasks are delegated (HCPC 2012, section 8).
- When a practitioner registers or re-registers with the Health and Care Professions Council, they are stating that they meet these standards.

5 Resources

The following resources are available:

- College of Occupational Therapists resources: the College's *Occasional paper on mentorship* (COT 2010c) explores what is meant by mentorship, its functions and benefits, and outlines the characteristics of good mentors and mentees.
- COT Library 'hOT topics' papers: these are available to download free from the Library section of the COT website. They list a useful range of literature, from journals, books and theses to a variety of internet resource leads. Those that might be of interest here are:
    - Supervision (COT 2006, February issue)
    - Continuing professional development (COT 2009, June issue)
    - Reflective practice (COT 2009, October issue)
    - Models of supervision (COT 2011, July issue)
- All are available to download from the College website: http://www.cot.co.uk/ (Accessed on 04.09.2014).
- The Social Care Institute for Excellence has a range of material in written and visual format available on its website: http://www.scie.org.uk/topic/developingskillsservices/managementleadership/supervision (Accessed on 04.09.2014).
- The Knowledge Network website of NHS Education for Scotland. This resource will support practitioners and managers to access resources that can help them with implementing supervision: http://www.knowledge.scot.nhs.uk/nmahpsupervision.aspx (Accessed on 04.09.2014).
- Skills for Care and the Children's Workforce Development Council (2007) *Providing effective supervision: A workforce development tool, including a unit of competence and supporting guidance*. Leeds: Skills for Care and CWDC: http://www.topssengland.org.uk/developing_skills/leadership_and_management/providing_effective_supervision.aspx (Accessed on 04.09.2014).

References

Borton T (1970) *Reach, touch, and teach: student concerns and process education*. New York: McGraw-Hill.

Care Quality Commission (2010) *Guidance about compliance: essential standards of quality and safety.* London: CQC.

Cassedy P (2010) *First steps in clinical supervision: a guide for healthcare professionals*. Maidenhead: Open University Press.

College of Occupational Therapists (In press) *Code of ethics and professional conduct.* London: COT.

College of Occupational Therapists (2014a) *Delegation briefing*. London: COT.

College of Occupational Therapists (2014b) *College of Occupational Therapists' learning and development standards for pre-registration education*. London: COT.

College of Occupational Therapists (2013) *Performance management briefing.* London: COT.

College of Occupational Therapists (2011a) Models of supervision (COT hOT Topic). London: COT

College of Occupational Therapists (2011b) *Professional standards for occupational therapy practice*. London: COT. Available at: http://www.cot.co.uk/standards-ethics/professional-standards-occupational-therapy-practice Accessed on 02.10.14.

College of Occupational Therapists (2010a) *Education paper. Lifelong learning is meaningful occupation*. London: COT.

College of Occupational Therapists (2010b) *Record keeping*. 2nd ed. London: COT.

College of Occupational Therapists (2010c) *Mentorship* (*COT Occasional paper 3*). London: COT.

College of Occupational Therapists (2009a) Continuing professional development (COT hOT Topic). London: COT.

College of Occupational Therapists (2009b) Reflective practice (COT hOT Topic). London: COT.

College of Occupational Therapists (2006a) *Developing the occupational therapy profession: providing new work-based learning opportunities for students.* London: COT.

College of Occupational Therapists (2006b) Supervision (COT hOT Topic). London: COT.

Department of Health (2013) *Patients first and foremost: The initial government response to the report of the Mid Staffordshire NHS Foundation Trust public inquiry*. (Cm 8576). London: Stationery Office.

Department of Health (2010) *Preceptorship framework for newly registered nurses, midwives and allied health professions*. London: DH.

Department of Health, Social Services and Public Safety (2013) *Regional supervision policy for allied health professionals*. Belfast: DHSSPS.

Department of Health, Social Services and Public Safety (2012) *Improving health and well-being through positive partnerships: a strategy for the allied health professions in Northern Ireland 2012–2017*. Belfast: DHSSPS.

Finlay L (2008) *Reflecting on 'reflective practice'* (PBPL paper 52). [s.l.]: Open University. Available at: http://www.open.ac.uk/opencetl/files/opencetl/file/ecms/web-content/Finlay-(2008)-Reflecting-on-reflective-practice-PBPL-paper-52.pdf Accessed on 02.10.14.

Flahault D, Piot M, Franklin A (1988) *The supervision of health personnel at district level.* Geneva: World Health Organization.

Gaitskell S, Morley M (2008) Supervision in occupational therapy: how are we doing? *British Journal of Occupational Therapy, 71 (3),* 119–121.

Great Britain. Parliament (2014) *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.* London: Stationery Office. Available at: http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents Accessed on 02.10.14.

Great Britain. Parliament (1974) *Health and Safety at Work Act 1974*. London: HMSO.

Health and Care Professions Council (2013) *Standards of proficiency. Occupational therapists*. London: HCPC.

Health and Care Professions Council (2012) *Standards of conduct, performance and ethics.* London: HCPC.

Howatson-Jones I (2003) Difficulties in clinical supervision and lifelong learning. *Nursing Standard, 17 (37),* 37–41.

McKinley M (2005) Mentoring: debunking the myths. *Healthcare Traveller*, 12 (10), 34–39.

Morley M (2012) *Preceptorship handbook for occupational therapists.* 3rd ed. London: College of Occupational Therapists.

Morley M (2007) Developing a preceptorship programme for newly qualified occupational therapists: action research. *British Journal of Occupational Therapy, 70 (8),* 330–338.

Morrison T (2001) *Staff supervision in social care: making a real difference for staff and service users*. Southampton: Pavilion Publishing.

NHS Wales (2010) *Doing well, doing better: standards for health services in Wales*. Cardiff: Welsh Assembly Government.

Nicklin P (1997) A practice centred model of clinical supervision. *Nursing Times, 93 (46),* 52–54.

Northern Ireland Practice and Education Council for Nursing and Midwifery (2013) *Preceptorship framework for nursing, midwifery and specialist community public health nursing in Northern Ireland.* Belfast: NIPEC.

Nursing and Midwifery Council (2006) *Preceptorship guidelines* (Circular 21/2006). London: NMC.

Proctor B (1987) Supervision: a co-operative exercise in accountability. In: M Marken, M Payne, eds. *Enabling and ensuring: supervision in practice*. Leicester: National Youth Bureau and the Council for Education and Training in Youth and Community Work. 21–34.

Rolfe G, Freshwater D, Jasper M (2001) *Critical reflection in nursing and the helping professions: a user's guide*. Basingstoke: Palgrave Macmillan.

Rose M, Best D eds (2005) *Transforming practice through clinical education: professional supervision and mentoring*. London: Churchill Livingstone.

Scottish Executive (2005) *Framework for role development in the allied health professions*. Edinburgh: Scottish Executive. Available at: http://www.scotland.gov.uk/Resource/Doc/55971/0015377.pdf Accessed on 2.10.14.

Scottish Government; Allied Health Professions Federation Scotland; AHP Directors Scotland (2013) *Allied health professions Scotland consensus statement on quality service values*. Edinburgh: Scottish Government. Available at: http://www.scotland.gov.uk/Resource/0043/00438291.pdf Accessed on 02.10.14.

Skills for Care; Children's Workforce Development Council (2007) *Providing effective supervision*. Leeds: Skills for Care; CWDC. Available at: http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/eOrderingDownload/Providing_Effective_Supervision_unit.pdf Accessed on 02.10.14.

Social Care Institute for Excellence (2013) *Effective supervision in a variety of settings* (SCIE Guide 50). London: SCIE. Available at: http://www.scie.org.uk/publications/guides/guide50/index.asp Accessed on 02.10.14.

Steventon E, Grandy S, Begum H, Amin M, Rashid C (2012) How to use clinical supervision to increase the use of evidence-based practice. [Online] *Health Service Journal*. London. Available at: http://www.hsj.co.uk/resource-centre/best-practice/care-pathway-resources/how-to-use-clinical-supervision-to-increase-the-use-of-evidence-based-practice/5040192.article#.VC1pOvldXk8 Accessed on 02.10.14.

Stoltenberg CD, Delworth U (1987) *Supervising counsellors and therapists: a developmental approach*. San Francisco: Jossey-Bass.

Sweeney G, Webley P, Treacher A (2001) Supervision in occupational therapy, part 3: accommodating the supervisor and the supervisee. *British Journal of Occupational Therapy, 64 (9),* 426–431.

University of Nottingham (2012) *Personal development and performance review guide: principles of constructive feedback*. Version 2.0. Nottingham: University of Nottingham. Available at: https://www.nottingham.ac.uk/hr/guidesandsupport/performanceatwork/pdpr/documents/pdprprinciplesofconstructivefeedback.pdf Accessed on 02.10.14.

Bibliography

Ayes J. Watkeys F, Carthy J (2014) Quality and effectiveness of clinical supervision: evaluation of an occupational therapy service. *British Journal of Occupational Therapy, 77 (9),* 447–450.

Bond M, Holland S (2011) *Skills of clinical supervision for nurses: a practical guide for supervisees, clinical supervisors and managers.* 2nd ed. Maidenhead: Open University Press.

Hawkins, P, Shohet, R (2000) *Supervision in the helping professions: an individual, group and organizational approach.* Buckingham: Open University Press.

Muirhead G (2013) *A phenomenological exploration of factors affecting the experience and performance of OTs with dyslexia at work*. MSc. Coventry: Coventry University.

Preston J, Lavalette H, Alexander J, Gilmour C, Allan J (2013) *Evaluation of the implementation of a model of supervision within the occupational therapy service*. Scotland. NHS Ayrshire & Arran.

Sweeney G, Webley P, Treacher A (2001) Supervision in occupational therapy, part 1: the supervisor's anxieties. *British Journal of Occupational Therapy, 64 (7),* 337–345.

Sweeney G, Webley P, Treacher A (2001) Supervision in occupational therapy, part 2: The supervisee's dilemma. *British Journal of Occupational Therapy, 64 (8),* 380–386.

Notes

Notes

Notes

Supervision

Guidance for occupational therapists and their managers

This guidance is Intended to enable practitioners and managers to set up healthy and effective supervision practices that will successfully meet the requirements of quality standards and strategy documents across the UK.

Topics covered include:

- The benefits of supervision for organisations, practitioners and service users
- Supervision as part of governance requirements
- Developing supervision where none is present
- Good practice when providing supervision

It also provides ideas and information that will be useful to those delivering and receiving supervision, along with those who are seeking to obtain or develop supervision in their workplace.

ISBN 978-1-905944-49-1
9 781905 944491

Download for BAOT members

www.COT.org.uk

College of Occupational Therapists

Royal College of Occupational Therapists

How CPD can be embedded into everyday practice

Almost any work-related activity can contribute to CPD as long as you keep track of what you have learned, how it can be applied to improve your practice and the benefit of using what you've learned for your service users and colleagues. We have expanded a recent article in OT news (Tempest and Parker 2016, 32-33) to include ideas from members who've collaborated with us to build a resource that we hope will help you to embed CPD into your everyday work.

CPD starts with you and stays with you. It is an aspect of our working lives over which we can take control. Your portfolio can be created in any way that suits you and what you show, to whom, is always your decision. It is important to start with yourself, consider your own needs and wants, how you see the future and what you are working towards in your life and career. Consider your strengths and weaknesses and what gaps there are in your learning and experience that you need to fill to move you in the direction you want to go. Plan to carry out CPD activities that build on your strengths to fill in the gaps.

While they need to align, it can be helpful to separate out thinking about the requirements of our regulator (the Health and Care Professions Council: HCPC) from personal CPD plans. Make your own plans and then you can review progress once you are under way just to check that you have met the baseline set by the generic regulatory requirements. Fulfilling CPD is learning that enhances working life and much more than an exercise in box-ticking that can feel bolted on to practice when CPD is not going well.

Here are some tips and ideas to act as a starting point:

- Find a like-minded colleague who you trust, so that you can critique your practice and identify where you would like to take your learning next.

- Joint sessions, where possible, are a good way of seeing how another practitioner works so that you can bring a fresh look into your own routine.

- Take a student on a practice placement; arguably the ultimate CPD activity for enhancing your own reasoning, leadership and management skills and a great opportunity to find out the current thinking in occupational therapy theory.

- Consider becoming an accredited practice placement educator to demonstrate your credentials in this area https://www.rcot.co.uk/practice-resources/learning-zone/apple-scheme

- 'Reflect, reflect, reflect': on your own reactions to undertaking an assessment, to a challenging interaction in a team meeting, to anything that captures your attention, and then act on those reflections in order to develop your skills.

Royal College of Occupational Therapists

- 'Record, record, record' https://www.rcot.co.uk then go to practice resources and click on learning zone and http://www.trammcpd.com/

- Capture one or two keywords a day that identify the new things you have learnt. If you get into the habit of looking for the learning, you will find it and then be able to record it.

- If you want to build an electronic portfolio there are free resources e.g. http://foliofor.me/

- When thinking about what you need to learn next in your career, think about it from the perspective of the clients and their families with whom you work; what do they need you to know?

- Take a look at RCOT's *Code of continuing professional development* and set yourself some small and doable work-based goals when you identify gaps in your learning. You can find it in the Appendix to the *Code of Ethics and Professional Conduct* or as a standalone document here on our website https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/rcot-standards-and-ethics

- Consider attending courses where you know the learning outcomes map onto what you need to learn, while appreciating that there is more to CPD than attending courses. Look out for RCOT annual awards and opportunities in your region or specialist section that may help with the funding too.

- Consider online courses, some of which are free. For example, RCOT contributed the occupational therapy pathway on the MindEd portal that provides free online learning about mental health for children and young people www.minded.org FutureLearn also regularly run free good quality courses www.futurelearn.com

- Once a year, on World Occupational Therapy Day, there is a free online twenty four hour conference for occupational therapists organised by the Facebook group OT4OT (online technology for occupational therapy) and WFOT (World Federation of Occupational Therapists called the occupational therapy 24 hour virtual exchange (OT24hrVX) that is then recorded with the discussions accessible for a year afterwards

- Make professional links outside your immediate workplace. RCOT's regional groups and specialist sections are a great place for mutual learning and support.

- Use supervision and your annual performance reviews/appraisals to reflect on what you have achieved and what you want to learn next. Resist the urge to just list what you have done.

Royal College of Occupational Therapists

- Use social media for your professional development: follow people within and beyond the profession, join in discussions and post your own thoughts (Maclean et al 2013). The RCOT *Social media briefing* and *Introduction to social media* can be found here https://www.rcot.co.uk/promoting-occupational-therapy/using-social-media

  You can join a vibrant online occupational therapy community by connecting to OTalk https://otalk.co.uk/ who hold regular tweetchats using the hashtag #OTalk and they are on Twitter as @OTalk_

  The wider online UK AHP community are found on Twitter at @WeAHPs and the various We communities with many social media resources to support CPD can be found here http://www.wecommunities.org/

- Ensure you select the right resource for the question you have and for the amount of time you have to find an answer. Practice guidelines, professional standards, review articles and briefings will all give you a quicker steer on a specific topic, as a lot of the work has already been done for you.

- Think how you can use CPD at work to keep occupation at the front of your mind and continuously strengthen your occupational therapy identity.

- Consider how the ideals you learnt as a student can be realised in the workplace as your focus on occupation becomes more sophisticated whilst remaining realistic.

- Find out if there's an OT curry night near you where people meet to socialise and learn over a curry. If there isn't (and you like curry) why not organise one through your RCOT regional contacts? https://www.rcot.co.uk/about-us/regional-and-local-groups/join-local-or-regional-group

- Host a topical discussion or brown bag lunch session with a few interested colleagues.

- Educate other people and this will firm up your learning as we learn best by teaching others. This can be done as part of Occupational Therapy Week in November and the link is on our website www.rcot.co.uk

- Devising a fun quiz to share with others can be a great way to explore your knowledge of a topic.

- Role-playing can help you prepare for a new challenge or see how you might have dealt with a critical incident differently.

- Practising a new technique in a safe setting away from your practice can give you the confidence to apply it at work.

- Find the methods and activities that best suit your own personality and your preferred learning style.

- Be courageous and step out of your comfort zone to take on new challenges and experiences.

- Run in-service training with an educational approach and try joint-collaborative working with colleagues from other professions

- A top tip for linking work and learning:

Whilst maintaining confidentiality, keep a private reflective diary where you can freely record your thoughts, feelings, ideas, dilemmas, questions and plans without any worry about being judged. You will thereby also be keeping a record of your professional learning that can form the basis for your portfolio. You can share edited extracts or distil questions that you want to take to others for discussion and identify gaps in your knowledge that you want to use your CPD to fill. You need time away from work to write your diary but you can jot down key words as a reminder and return to write and think about them when there's some time and space.

Thank you to all the OTnews respondents and the delegates from our new graduate event for sharing their thoughts to co-create this resource.

Maclean F, Jones D, Carin-Levy G and Hunter H (2013) Understanding Twitter. *British Journal of Occupational Therapy*, 76(6): 295-298.

Tempest S, Parker Z (2016) Time to get personal: reclaiming CPD as a reflective mind-set. *OTnews*, (24) 6: 32-33.

Occupational Therapy Supervision Protocol

Introduction

Supervision was defined by the College of Occupational Therapists in 1990 as' a professional relationship which ensures good standards of practice and encourages professional development'. This definition was expanded in 1997 to incorporate 'supervision is not the equivalent of performance review, of counselling or of monitoring; it is a relationship concerning accountability and responsibility for work carried out' (COT/ BAOT briefings 2006).

More detailed direction has also been provided recently by the College of Occupational Therapists following the publication of the document 'Supervision – Guidance for Occupational Therapists and their managers' COT April 2015.

The Northern Ireland Regional Supervision Policy for Allied Health Professions (December 2013) says `Supervision should be available to all AHP staff in four areas of professional activity: **Clinical, Professional, Managerial, and Operational**, on an interpersonal and supportive basis'.

Table 1

1. CLINICAL SUPERVISION:	*Relates to Assessment, Clinical Reasoning, Formulation, Therapeutic Intervention, Decision Making, Consultation, Legislative Context/Statutory Functions, Case reviews and other Clinical Activities*
2. PROFESSIONAL SUPERVISION:	*Relates to Scope of Practice, CPD, Professional Guidelines and Ethical Guidelines*
3. MANAGEMENT SUPERVISION:	*Relates to Trust/Professional policies & procedures, Employee workload & allocation of work, Quality of employee's performance, Statutory responsibilities, Recordkeeping & professional standards, Service- user's needs and Risk Management*
4. ORGANISATIONAL SUPERVISION:	*Relates to Organisational changes & initiatives, Resource Management, Staffing issues-representation/developments, Policy clarification and Conflict resolution*

HCPC standards for registration require OTs to demonstrate competence through CPD which includes evidence of supervision activity. This supervision activity also links with the Belfast Health and Social Care Trust's Personal Contribution Framework, incorporating the national Knowledge and Skills Framework, as a key aspect supporting staff development.

Guidelines

.

- Supervision as defined in the Northern Ireland regional policy should operate at all professional levels in the organisation up to Professional Head of Service
- All professionally qualified and support OT staff (including temporary and agency staff) employed by the Trust with direct care roles can expect to have appropriate access to supervision.
- Supervision may include activities such as audit, case discussion/review, either on a random or case selection basis, staff / team meetings or examination of user feedback.
- Newly Qualified Practitioners will be supported in following the Perceptorship framework as per the COT guidelines.
- Professional line managers are responsible for identifying the most appropriate supervisor.
- Where specialist clinical approaches are being used clinical supervision should take place according to OT professional standards and clinical guidelines.
- It is a requirement for all practitioners to ensure that they engage in clinical, professional, managerial and operational supervision
- It is the responsibility of supervisor and supervisee to ensure that a record of supervision is kept. (Appendix 1 Supervision Record Form)
- There is a range of formal and informal supervision models including collegial, peer, co supervision, telephone and individual/ group supervision and managers may use the most appropriate model where necessary.

Supervision Principles

The first session with a new member of staff will include a Review of Regional AHP Supervision Policy, which identifies the purpose and aims of supervision and will result in a supervision schedule being agreed by the supervisor and supervisee.

The service expects that supervision occurs no less than 4 times per year, where at least one of these sessions is on a 1-1 basis. However the number of supervision sessions per year is based on the competency of a person, not the grade of the post and may vary according to caseload mix, individual OT requirement, service location and working patterns.
Those new to a post/ clinical area or role can expect more regular supervision as part of induction and/or Perceptorship.

This frequency schedule is a guideline only

New to post/role : 1-2 months -weekly
3-6 months – fortnightly

Probationary period completed: Monthly

Top gateway of KSF framework: Bi –monthly

Both supervisor and supervisee must prepare for supervision by

- Agreed items for discussion are drawn up at the start of each supervision meeting with contribution from both supervisor and supervisee.
- Decisions made at previous supervision meetings are reviewed to ensure agreed actions have been taken.

Record Keeping

Written or electronic records of individual sessions, as per the agreed proforma, must be taken, remain confidential and record clearly any agreed actions.
Any differences of opinion should be recorded.
If manual records are kept they must be signed by the supervisor and supervisee; a copy of them may be retained by the supervisor.
In cases of electronic recording a signature is not required, but both parties should retain the information that is shared.

A written record of attendance at group supervision sessions should be retained with notes of actions agreed and circulated to all attendees.

Informal supervision addressing specific concerns related to individual clients should be recorded in the individual client's case notes.

Where there are issues of concern this should be dealt with supportively via appropriate procedures. There may be times when the supervisor needs to raise an issue through their line management.

Supervision sessions are generally confidential between the supervisor and supervisee however if required the records may be used in cases of grievance or disciplinary procedures.

Records should be stored securely in line with Trust policy.

When a supervisor is not available e.g. during annual leave, an alternative qualified member of staff must be identified as being available to be called upon in the event of an emergency or untoward incident or for informal supervision.

Review September 2016

Belfast Health and Social Care Trust

OCCUPATIONAL THERAPY DEPARTMENT

Supervision Record

Name of staff member:	**Date**
Supervisor:	

Instructions

a. Insert number in left hand column to reflect type/topic of supervision discussed

b. Supervisor and Supervisee should sign after the final entry

1. Case reviews & workload allocation	**5. Departmental/Service responsibilities**
2. Record Keeping & professional standards	**6. CPD /Training**
3. Organisation of work/ time management	**7. Audit/ research/quality initiatives**
4. Staff/Student contact	**8. Other**

No:	Agenda items for discussion

Agenda item No	Issues discussed

Agenda item No	Issues discussed

Occupational Therapy Learning Disability

Inservice Programme 2014/15

Date	Topic	Location
Wednesday 26th Nov 2014 2pm	Sensory Attachment Overview	Conference room , Finaghy HC Clare Donahue – Clinical Lead OT, CAMHS
Wednesday 25th Feb 2015 10am	IQ Assessments	MAH Siobhan Keating – Consultant Forensic Psychologist, MAH
Monday 6th July 2015 2-4pm	Peer supervision	Finaghy HC
Wednesday 29th July 2015 2-4pm	Epilepsy and LD	Finaghy HC Ena Bingham
Wednesday 19th August 2-4pm	Overview of financial capacity and money management with people with LD	MAH Katie Carson
Friday 4th September Time TBC	Sensory Integration and Peer Supervision	MAH Olivia Boyle
Friday 11th September (Full day)	Pressure care	MAH Shelley Crawford
Friday 18th September (Full day)	Postural management	MAH Shelley Crawford
Friday 25th September Time TBC	OT assessments in LD	MAH Shelley Crawford and Katie Carson
Wednesday 28th October	Peer Supervision	Carlisle HBC
Wednesday 25th November	LD and the environment (presenting her MSc thesis)	Finaghy HC Heather McFarlane
December	NO INSERVICE	

The Chartered Society of Physiotherapy [CSP]
CSP Education Position Statement:
Continuing Professional Development

Introduction

This position statement sets out the approach that the Chartered Society of Physiotherapy (CSP) takes to post-registration continuing professional development (CPD). As the UK's professional, educational and trade union body for physiotherapy, the CSP seeks to shape and support the development of CPD and career pathways for its members as described in this document.

This statement may be used with members to illustrate the CSP's approach to continuing professional development and to help them to make the case to their employers for supporting both their own learning and development and that of others. It also provides information for government departments and bodies, education providers, employers and other professional bodies or trade unions about our expectations of provision of CPD opportunities for members and their responsibility for maintaining appropriate levels of CPD. In doing this, we seek to influence and inform workforce planning and development at a national, regional and local level.

The position statement will be kept under review to ensure its currency and updated as necessary.

Scope

As the educational, professional and trade union body for 53,000 chartered physiotherapists, physiotherapy students and support workers, the CSP leads and supports the development of the UK's physiotherapy workforce to ensure that it continues to be fit for purpose as population healthcare and service needs change. This is achieved by working with and through members to influence and inform the strategic and policy developments shaping the education, employment and professional practices of the physiotherapy workforce at a national, regional and local level. Supporting and facilitating CPD opportunities for members is fundamental to achieving this objective.

CSP's approach to continuing professional development

CSP members are required to engage in CPD in order to remain registered with the HCPC. As stated in the NHS Constitution "employers have responsibility for investment in the skills and development of the people they employ". It is our expectation that all employers, whether in the NHS or other sectors, will facilitate CPD opportunities for their employees, and that all CSP members, whatever their working context, will allocate time to their learning.

The CSP supports the development of autonomous critical learners who can maintain professionalism, adapt their scope of practice in response to the changing evidence base, and lead and support the development of high-quality effective and efficient services that meet changing population needs. This objective is met by adopting an outcomes-based approach to CPD, focused on how members' learning relates to their ability to deliver appropriate physiotherapy practice that meets the needs of service users. CSP resources and approaches apply a blended critical approach to CPD that is responsive to developments in health and social care, education and technology. By these means members maintain and develop their skills, knowledge and competence in order to practice safely and effectively, to deliver person-centred care, demonstrate leadership and support their own learning and that of others.

In the light of ongoing changes in expectations of practice, the CSP supports its members' CPD to facilitate further development of values, behaviours, knowledge and skills to enhance their contribution to the delivery of excellent healthcare and health improvement. In order to deliver excellent healthcare members need access and engage with quality learning opportunities, and then to consolidate and integrate their learning into practice. It is crucial, therefore, for employers to facilitate individuals' learning and development in the form of physical access to learning communities, materials and technologies and/or time out of their working role to engage in learning and development activity.

From an organisational perspective, support for CSP members' CPD enables employers to address the governance issues emerging through the post-Francis agenda by assuring that the physiotherapy workforce can meet professional and regulatory requirements and continues to be fit for purpose.

Key references and further reading
The CSP continually refreshes and supplements the CPD resources we provide to members, and the following list is a selection of the materials that are available.

Developing/accessing quality learning opportunities
CSP Learning & development principles
CSP Physiotherapy Framework
CSP quality assurance standards – section 3: learning & development
CSP Charitable Trust webpages – funding to support learning and development
Thinking about courses (members) – Frontline 20.07.2011
A beginner's guide to e-learning – Frontline 07.01.2015

Becoming an autonomous critical learner/practitioner
Professionalism section of CSP website
CSP CPD resources
Championing CPD Habits
CSP ePortfolio CPD information, tools and eLearning materials
Learning & development network on iCSP

CPD and quality employment
CSP Your business/Delivering under pressure
Grademix [Downbanding]: protecting the grades of members working in the NHS (ERUS IP07)
Safe and sound resources
CSP Championing CPD project (learning champions)

References
Department of Health (2013) A mandate from the government to Health Education England
Department of Health (2013) The Cavendish Review
CSP (2011) *Code of members' professional values and behaviour.* Available at www.csp.org.uk/code
West M et al (2014) *Developing collective leadership for healthcare.* London; the King's Fund. Available at http://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care
CSP (2012) *Quality assurance standards.* Available at www.csp.org.uk/standards
Department of Health (2013) The education outcomes framework. Available at https://www.gov.uk/government/publications/education-outcomes-framework-for-healthcare-workforce

CLINICAL SUPERVISION: A BRIEF OVERVIEW

Looking through the practice & educational literature, there is no single definition of clinical supervision, but one that is often cited within healthcare (comes from a nursing perspective) that seems to capture the purpose of the supervisory relationship comes from Butterworth & Faugier (1993)

'An exchange between practising professionals to enable the development of professional skills'

This is a useful definition because of how it aligns with an outcomes-based approach to CPD which is consistent with the HCPC's expectations of registrants, & the CSP's expectations of its members.

Implementation of this model of clinical supervision can sometimes cause tension in practice – because of the link between clinical supervision & clinical governance. If clinical supervision is directly linked to clinical governance, questions need to be asked about the supervisory relationship: is clinical supervision in place to facilitate/enhance individuals' learning & development? or is it about enabling the organisation to evaluate the competencies of individual members of staff?

There is no right or wrong here. What's important is that the supervisor & supervisee both know what clinical supervision is doing – because that will influence how the supervisory process & relationship are managed.

Some of the more recent literature around models of supervision is helpful in taking the idea of supervision as an (empowering/enabling) relationship between 2 people to one that takes account of/acknowledges the organisational context in which that supervisory relationship is happening. It then becomes possible to critically evaluate how clinical supervision can enhance outcomes (at an individual & organisational level) as well as how organisational cultures/practices can limit/enhance that development.

Clinical supervision in practice

On a practical note, it would wise be to explore what staff want from 'clinical supervision' (what are the outcomes) & to consider how that aligns with organisational requirements. If they are vastly different, you would then need to start evaluating the relative benefits of different approaches - & how it might be possible to develop a model of supervision that meets staff's expectations of supervision that also enables a department/service to meet organisational targets/demands & governance (e.g. how might your model of supervision enhance client outcomes, staff recruitment/retention, productivity etc). It would also be advisable to support your argument with reference to professional expectations e.g. HCPC's standards of conduct, performance & ethics, & CSP's Code of professional values & behaviours etc.

Based on a review of existing models and underpinned by the Society's approach to CPD, CSP has drafted a set of prompts to help members develop systems of clinical supervision with meet the requirements of all individuals.

Principles.
Clinical supervision should:
1. Support & enhance practice for the benefit of patients/service users
2. Develop skills in reflection to narrow the gap between theory & practice
3. Involve a supervisor & practitioner or group of practitioners reflecting on & critically evaluating practice
4. Be distinct from formal line management supervision & appraisal
5. Be planned & systematic & conducted within agreed boundaries
6. Be explicit about the public & confidential elements of the process
7. Facilitate clear & unambiguous communication, conducted in an atmosphere of beneficence
8. Define an outcomes based action plan.
The outcomes could then be more broadly developed to assist the practitioner's professional development through the appraisal process
9. Be evaluated against set standards from the time it is initially developed & implemented

The clinical supervision process should:
10. Involve all individuals in the service, signed up to by staff & supported & resourced by management
11. Be developed in partnership with managers & practitioners
12. Be supported by appropriate resources (time, training, replacement staff)
13. Facilitate practitioner access to their chosen model of supervision, as appropriate
14. Support a local system for supervisors to further develop their skills in facilitation
15. Be developed in parallel with collating a portfolio of learning, so that the practitioner is supported to develop & demonstrate skills of reflection & evidencing learning from experience.

Additional resources:
DoH (2010) Preceptorship framework for newly registered midwives, nurses & AHPs

CSP's Physiotherapy Framework defines & describes the behaviours, knowledge & skills used by the physiotherapy workforce – at 6 levels of practice. Its content might be helpful for thinking about the nature of/requirements for clinical supervision at different levels of practice as well as the behaviours/knowledge/skills gained through supervision. Click **here** to access a workbook based on the CSP Physiotherapy Framework domains/descriptors from the CSP's website.

February 2017

Belfast Health and Social Care Trust

caring supporting improving together

BHSCT Physiotherapy Service

Guidance for the Implementation of Clinical Supervision May 2016

Content

Appendices:

1. Introduction

This guidance has been produced to support the implementation, development and evaluation of clinical supervision for physiotherapists working in Belfast Trust.
In the context of the AHP strategy and recent enquiries (Lewis review, Murtagh review , McCleery report and Mid Staffordshire enquiry) and the guiding principles of Quality 2020 and Transforming Your Care it is essential that robust governance arrangements, including supervision, exist to ensure the delivery of safe, effective high quality care.
The regional Supervision policy for AHP's (2014) outlines the need for professional performance supervision and appraisal to ensure the delivery of a high quality AHP service. The policy document sets out a formal process for how this should be achieved in the workplace and underpins our supervision policy
The HCPC, our regulatory body, places responsibilities on both the employer and employee that must be fulfilled to safeguard public protection. Access to regular supervision is a key factor in ensuring effective governance and accountability. This guidance will ensure a standardised approach to the delivery of clinical supervision underpinning high quality, safe and effective practice.

2. Purpose

This policy will ensure the processes and systems are in place to support professional supervision.
Supervision will support professional regulation and the clinical governance agenda contributing to continuing professional development. It facilitates professional and personal development supporting learning and enhancing the knowledge and skills required to carry out a role and deliver high quality care.
It will develop a highly skilled, competent and motivated workforce enabling us to meet the challenging service needs while simultaneously protecting and improving the quality of care provided. Good quality supervision underpins high quality, safe, effective practice

3. Clinical Supervision
3.1 Definition

Supervision refers to ‘a formal/informal arrangement, which enables a therapist to discuss his or her work performance in a safe environment with someone who is experienced and qualified’.

The CSP describes clinical supervision as “a collaborative process between two or more practitioners of the same or different professions. This process should encourage the development of professional skills and enhanced quality of patient care through the implementation of an evidence-based approach to maintaining standards in practice. These standards are maintained through discussion around specific patient incidents or interventions using elements of reflection to inform the discussion” (CSP, 2005).

3.2 Core Values and Principles

The following are the core values which underpin the supervision policy document.

- Supervision must ensure the effective management of practice by developing and supporting staff and promoting staff engagement within the organisation.
- The quality of supervision has a direct bearing on the quality of service delivery and outcomes.
- All staff members, irrespective of their role, have the right to receive high quality supervision.
- The supervisory process will promote and protect the best interests of staff & service users irrespective of differing political opinions, race, religious or cultural views, age, marital status, sexual orientation or disability.
- All staff members bear responsibility for the quality of their own work and are required to prepare for and make a positive contribution to the supervisory process. They are not passive recipients.
- Supervision should be available to all AHP staff in four areas of professional activity: **Clinical, Professional, Managerial, and Operational**, on an interpersonal and supportive basis.
- Trusts have a responsibility to promote good supervision by implementing this policy and ensuring training is provided for both supervisors and supervisees.

3.3 Aims of Supervision

Clinical supervision is undertaken within a culture of learning and should:

- Support the individual to develop the knowledge, skills and attributes to meet their learning needs with the focus being safe and effective practice
- Support the individual through difficult and challenging complex client caseloads or difficult interpersonal contacts
- Support the individual to meet the CPD requirements of the CSP/HCPC, competency levels outlined in their KSF and Trust Objectives outlined in the appraisal process
- Develop self-awareness by facilitating reflective practice and clinical reasoning
- Ensure the delivery of a high quality, safe and effective service for patients
- Support individuals in non-clinical roles by providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and/or professional issues

What it is not:

Fieldwork/clinical education: the education and training of students on pre- and post-qualifying programmes

Mentorship: a nurturing relationship between an experienced professional and one who usually has not progressed as far in their chosen career which involves discussion on broader personal and professional development, not specifically clinical development. Those involved are not necessarily of the same professional background

Appraisal/development review: a formal, management-led assessment of the quality completion of set professional objectives and personal development activities. Usually done on a 6 or 12 monthly basis with additional formal reviews as deemed appropriate
Peer review: an evaluation of the clinical reasoning about a patient episode by a peer at a similar clinical level using patient case notes to guide the discussion. Practitioners should select their own peer or peers and the process is carried out informally. Peer review tends to have a narrower professional focus than clinical supervision

Counselling: a therapeutic process encouraging resolution of personal, emotional issues linked to past experiences. The counsellor is not usually of the same professional background

Preceptorship: a term predominantly used in nursing indicating the support period undertaken to support newly registered nurses

4. Supervision Processes

4.1 Frequency/ duration/ location

Formal supervision should be available on a regular basis not less than four times per year.

Informal supervision should be provided on an on-going basis as required. Informal supervision can be carried out on a daily basis where help is sought regarding Clinical, Professional, Managerial and Operational issues from Peers and Managers.

The main form of supervision should be formal one to one supervision but professional managers may deploy team or group supervision techniques where appropriate.

Time allocated per supervision session should be adequate to address the aims and objectives of the specific session.

The location should be conducive to having a confidential discussion without interruption. If the session is cancelled this is recorded in the documentation and a new date and time arranged.

4.2 Receiving Supervision

All AHP staff should receive regular supervision either formally or informally.
Formal supervision should be available in four areas of professional activity.

- **Clinical**: defined as " supervision that relates to all clinical activity; the processes involved in case management, assessment, clinical reasoning, formulation, therapeutic intervention, decision making, consultation, consideration of legislative context and statutory functions, case evaluation/case review status and other wider and more systemic clinical activities". The aim is to promote best clinical practice through the process of reflection, discussion and review of all aspects of the clinical task and client/therapist relationship. Staff providing supervision in this area should be working within the same area

- **Professional**: all staff should have access to a Professional Line manager of the same profession for issues relating to scope of practice, CPD, AHP role, Professional Guidelines, ethical obligations and broader Professional issues. The supervisor ensures that CPD functions set down by the HCPC are met.

- **Managerial**: within managerial the supervisor ensures that the management function (competent, accountable performance) is met to include policies/procedures, workload prioritisation, performance, statutory responsibilities, records and appraisal.

- **Operational**: the supervisor ensures engagement of the individual with the organisation by communicating organisational changes, representing staff need to management, seeking policy clarification, consulting with staff and negotiating on differences.

Where managerial and operational supervision is carried out by a supervisor from a different professional background there is a need for the Professional manager to undertake clinical and professional supervision separately. Sufficient time should be given to the four different areas with appropriate balance and sharing of information to work in partnership. Professional and Operational line managers are jointly responsible for ensuring that all four areas of supervision are addressed.

4.3 Training

Supervisors and supervisees must have completed the appropriate training to carry out their supervision roles. Supervisors will attend designated training within an agreed timescale of taking up their first supervisory/management post. Refresher training should be available to consolidate skills. Where supervision training is not complete Staff new to the supervisory role should observe an experienced supervisor to gain insight into the process (with consent of all involved).

4.4 Providing Supervision

All qualified AHP staff may regularly be expected or asked to provide supervision to a range of grades of staff within their own discipline. Supervision should not be subject to cancellation and is only postponed in exceptional circumstances and reconvened at the earliest opportunity. Both the supervisor and supervisee must prepare for each session. Agreed items for discussion are drawn up at the start of the session with contribution from both parties and any decisions made at previous supervision meetings are reviewed to ensure agreed actions have been taken.

4.5 Recording Supervision

The supervision contract should be read and signed prior to beginning supervision. All supervision sessions should be recorded promptly, competently and stored correctly using the relevant proforma.
All records are maintained on the correct Service Documentation and should either be typed or written legibly in clear print. The date and time of each supervision session should be recorded along with a brief outline of areas discussed and the completed record agreed and signed by both the supervisor and supervisee. Records remain confidential and record clearly any agreed actions.

5. Confidentiality

Supervision sessions are in general confidential exchanges between supervisor and supervisee. The record is however an organisational document that may be viewed by others if required and may also be used where there are situations like grievances or disciplinary proceedings.

All parties must be informed of the intention to disclose before revealing confidential information

6. Evaluation

The impact of supervision on the individual, the team and service needs to be evaluated. A monitoring process will be in place to provide assurances that implementation is completed. It will also be essential to ensure that Supervision Policies and Procedures are meeting service need and meeting all four functions of Supervision.
Supervisees will be evaluated to monitor the benefits of supervision. All supervisors and supervisees must comply with these processes and make data available for collation.

The Association of UK Dietitians

BDA Practice Supervision

Contents

1. Background and Getting Started

1.1 Introduction

This Practice Supervision Guidelines document has been developed by a working group of the BDA to update the previous Clinical Supervision Guidelines. The document details the process of practice supervision and provides some practical tools that can be used when developing and implementing supervision in any work related environment. This document encompasses all members of the dietetic profession including those working in the freelance setting and dietetic support workers. It is acknowledged that supervision structures may be more difficult to establish when working in isolation and may have to take other forms than face-to-face contact.

Practice supervision is part of the Governance Framework. It should be included within working practices and not considered as an "add on". It is integral to delivering a quality service and should be embraced by the practitioner to enhance professional practice. By exploring work-based scenarios and reflecting upon practice, the practitioner will have the opportunity to develop not only themselves, but also the employing organisation.

1.2 What is Practice Supervision?

For the purpose of these guidelines we have used the term "practice supervision in place of the traditional term "clinical supervision". The rationale is to encompass practitioners working in a wide variety of settings, not just the NHS. It will avoid discrimination and highlight the benefits practice supervision can bring to the practitioner, the work environment and the service user. Practice supervision is equally important and for all grades of staff and the wider workforce working in the service, i.e. nutritionists, support workers, admin and clerical staff.

Definition:

> *"Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individuals to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety of care.*
>
> (Adapted from www.dhsspsni.gov.uk)

Supervision does not have to be given by a member of the same profession. It can be delivered across professions and across multi disciplinary teams. Within some professions, supervision can encompass all dimensions of a post holder's work including caseload, workload, professional management and personal day-to-day supervision.

1.3 Key Drivers

Practitioners working in any setting should be aware of their individual accountability for their practice. This is a key component of the governance framework. Practitioners should also be aware that they work in a climate of change with the expectation that they will continually have to meet new challenges. Practice supervision will help practitioners improve their practice and manage change. The supervision process can directly influence continuous professional development and the governance agenda.

The Health Professions Council (HPC), as the regulatory organisation for Allied Health Professionals (AHPs), has set Professional Standards of Continuing Professional Development (HPC, 2006). Continuing to update and extend knowledge and skills is an essential feature of maintaining the competency of professional practice. All HPC registrants are required to undertake continuing professional development (CPD) in order to maintain registration. Returnees to practice are also required to undertake CPD to regain registration. Evidence of continual education and training for dietitians will be formally requested by the HPC in 2010 and assessed on an ongoing basis.

Access to practice supervision is therefore a core element of the personal responsibilities a dietitian has to ensure that they remain fit for purpose and fit to practise throughout their career, whatever their scope of practice may be.

Dietetic support workers and the wider workforce employed in the service are also required to undertake CPD to meet their Knowledge and Skills Framework (KSF) outlines and competencies to practice.

Practice supervision facilitates life-long learning, engagement in self-development and identification of training needs. It also provides opportunities for professions to learn and develop together to ensure the practitioner remains flexible to changing practice and models of service delivery. Practice supervision sessions can be used continuously to review KSF skills, support the practitioner in their development and agree evidence that can be used at an annual appraisal. It is a complementary process.

The process of practice supervision links to two national workforce competencies (NWC) profiled at www.skillsforhealth.org.uk. The two that relate to supervision are GEN33 and GEN35. This maps to KSF Core Dimension 2; People and Personal Development.

For the organisation, practice supervision is described as improving multidisciplinary team working, enabling the development of Standards of Practice and enhancing the quality of services to service users.

Evidence from research shows that practice supervision combined with mentorship has a beneficial effect for all staff, irrespective of grade, length of service or occupational setting. The extent that these are felt will depend on the extent to which practice supervision is

properly implemented. In those circumstances where it has been withdrawn, there are measurable detrimental effects on the workforce (Butterworth, 1997). The table below summarises practice supervision.

What it is	What it is not
Supportive	Not appraisal
Contributes to continual development of skills/knowledge, understanding and future practice	Not a whinging session
Guided reflection which allows the individual to learn from positive and negative experiences	Not an assessment of practice
Focus on practice supervision	Not management supervision
Led by the supervisee	Not an assessment of quality of an individual's work

1.3.1 Practice Supervision VS Management Supervision

It is vitally important that staff do not confuse the boundaries of practice supervision and management supervision, particularly where practice supervision is a new concept to a department or where this has yet to be introduced.

Management supervision may address the agendas of both the supervisee and supervisor, whereas practice supervision is led by the agenda of the supervisee.

Examples of management supervision topics are monitoring and evaluating practice, time management, management of other staff, resource management and management of workload.

All staff and managers should be aware of the differences as highlighted above and should accentuate the positives of practice supervision.

1.4 Principles of Practice Supervision

The key principles of practice supervision outlined below must be promoted. This can be done by presentations to staff, provision of reading materials, or undertaking training courses. Further training by internal or external providers should support this.

The following practice supervision principles are well recognised within the Allied Health Professions. Local arrangements will need to take account of these guiding principles in developing systems which meet the requirements of all individuals working in a range of settings.

1.4.1 Principles

- Support and enhance practice for the benefit of service users.
- Develop skills in reflection to narrow the gap between theory and practice.
- Involve a supervisor and practitioner or group of practitioners reflecting on and critically evaluating practice.
- Be distinct from formal line management supervision and appraisal.
- Be planned and systematic and conducted within agreed boundaries.
- Be explicit about the public and confidential elements of the process.
- Facilitate clear and unambiguous communication, conducted in an atmosphere of beneficence.
- Define an action plan based on outcomes. The outcomes could then be more broadly developed to assist the practitioner's professional development through the appraisal process.
- Be evaluated against set standards from the time it is initially developed and implemented.

1.5 Who benefits from Practice Supervision?

Benefits to the individual practitioner	Benefits to the organisation	Benefits to the service user
• Provides a safe and supportive environment to enhance personal and professional development. • Uses guided reflection to aid learning from both positive and negative experiences. • Provides ring-fenced time for reflection. • Enables the practitioner to question his/her own practice. • Enables the practitioner to be challenged by their experiences. • Provides a framework to identifying personal learning needs. • Safeguards standards of practice.	• Compliance with Government and Statutory body agendas. • Directly linked to Clinical Governance Agenda. • Safeguards standards of practice, reducing risk. • Improves the environment of care. • Promotes excellence in delivering high quality service for all. • Helps develop existing and new career paths. • Improves staff morale/satisfaction. • Supports staff retention. • Decreases sickness and absence.	• Quality service from staff who receive appropriate support as and when required to meet need. • Helps maintain standards of care.

• Increases feeling of support and personal well being. • Increases knowledge and awareness of possible solutions to practice problems. • Increases confidence, decreases incidence of emotional strain and burnout. • Increases self awareness.	• Demonstrates the value of the practitioner. • Develops and promotes a learning culture in the organisation.	

1.6 Person Specification – Practice Supervisor

There are particular qualities and skills required in order to be an effective supervisor.

Professional qualities	Personal qualities	Skills
• Relevant practice experience in the field within which practice supervision will be provided. • Good understanding of the philosophy behind practice supervision and the responsibility of a practice supervisor • Delivers high standards of evidence-based practice. • Engaged in continuing professional development.	• Desire to undertake the role of a clinical supervisor. • Good interpersonal communication and listening skills. • Approachable and unbiased when dealing with others. • Trustworthiness and ability to maintain confidentiality of information. • Ability to reflect in action and facilitate constructive reflection from supervisee. • Ability to accept and respect views of supervisee. • Openness and supportive.	**Managing the process:** To structure and organise the process in line with the contract which has been established. • Monitoring • Managing time • Using intuition • Reviewing and evaluating • Decision-making and action planning **Developing and maintaining the relationship:** To develop rapport and maintain a process that will underpin the process. • Active listening • Reflecting back and paraphrasing • Self-disclosure

	• Ability to be challenging but non-threatening. • Self awareness of beliefs, prejudices and motivations. • Empathy	**Carrying out the supervision tasks:** To facilitate the different tasks at each stage of the process. • Questioning • Focusing • Using silence • Giving constructive feedback • Inform

1.7 Responsibilities of the Supervisee and Supervisor

The relationship between the supervisor and supervisee is an important one and it is recommended that the supervision is supervisee-led. However the supervisor should take responsibility to ensure there is a balance between support and challenge for the supervisee within the session. Awareness of supervisee and supervisor roles is fundamental for this relationship to develop and should be discussed when agreeing the contract and be regularly reviewed. Supervision does not need to be undertaken by someone of a higher grade.

Responsibilities of a supervisor	Responsibilities of the supervisee
• Establish a safe environment to explore practice issues. • Negotiate a supervisory contract and agree professional boundaries about what issues will be discussed. • Arrange supervision sessions to include dates, venues and agendas. This responsibility could be shared with the supervisee. • Ensure supervisee has access to supporting paperwork, e.g. meeting record sheets.	• Negotiate a supervisory contract and agree professional boundaries about what issues will be discussed. • Commit to attending supervision sessions and actively participate. • Undertakes preparation as is required to maximise the effectiveness of the supervision experience. • Bring to supervision sessions topics, case studies and issues to share and discuss, and to be prepared to reflect on this situation, e.g. workload, prioritisation, clinical reasoning, clinical management etc.

• Ensure meetings are documented with agreed action plans and timescale. • Keep supervision sessions confidential between the supervisee and the supervisor *. • Share responsibility for making supervision work. • Help supervisee to explore and clarify thinking and feelings. • Be non-judgemental, listen actively and challenge constructively. • Give clear supportive and constructive feedback. • Withdraw from the supportive relationship if unable to meet the requirements of the agreement.	• Be open to constructive feedback. • Complete a reflective log of supervision sessions and action points with timescales as required. • Keep supervision sessions confidential between supervisee and supervisor*. • Accept appropriate responsibility for performance, learning and professional development. *Both the supervisee and supervisor have a responsibility to abide by their professional Codes of Conduct and HPC standards. Where there are any concerns that professional standards are not being maintained and that this adversely affects practice then this must be reported outside of the supervision session. This will be implicit as part of the contractual agreement when a supervision contact is agreed.

1.8 Implementation of Practice Supervision

The success of implementing practice supervision is dependent on creating a culture where individuals are valued. This value is demonstrated in terms of time for personal and professional development to support practice in its broadest sense. Valuing supervision is important for the process to progress and develop. It requires continuing motivation and commitment from staff and recognition that this process cannot be rushed. Management support cannot be underestimated to allow staff to organise the necessary time that practice supervision requires.

In order for practice supervision to be accepted by the service, it is essential that all practitioners are involved in the process. A practice supervision system implemented from the top down can be viewed as another process of management control. It may alienate the practitioners it is intended to support. However, although a "bottom up" approach is recommended, it must have the support of management who will be responsible for allocating resources to support the system and for assessing the impact of practice supervision on the service. Therefore the development and establishment of practice supervision should involve both managers and staff.

Sufficient time should be given to introduce a system that all staff will see as a high priority. Ensure a realistic timeframe is set to introduce, deliver and evaluate formal practice supervision. In addition to time spent on the actual process of implementing practice supervision sessions, the practitioners' ring-fenced time away from the service users during sessions will add pressure to their involvement in the supervision process. It is essential that both staff and management recognise and accept that time is well spent in practice supervision.

1.8.1 Implementation process of practice supervision

- Involve all individuals in the service, sign up staff and ensure management provide support and resources.
- Develop in partnership with managers and practitioners.
- Ensure support with appropriate resources (time, training, and replacement staff).
- Encourage staff to access BDA CPD policy and review BDA tools for reflection. The tools can also be used to support and prepare for supervision.
- Facilitate practitioner access to their chosen model of supervision, as appropriate.
- Support a local system for supervisors to further develop their skills in facilitation.
- Develop in parallel with collating a portfolio of learning, so that the practitioner develops skills of reflection, articulating and evidencing.

  A practice supervision action plan is detailed in Appendix 1.

1.9 Audit and Evaluation

For practice supervision to be seen as an effective process, an audit of the system should be carried out. Recommended timescale of implementation for the audit process is on an annual basis, or after the sixth session as a minimum. This may be subject to negotiations at a local level. It is good practice to present the evaluation report to management and outcomes cascaded to staff. By providing evidence to assure staff and management of the benefits of the system, it should ensure its continuation.

Potential audit markers are:

- Safer clinical practice.
- Better assessment of patient/client.
- Improved patient satisfaction surveys.
- Reduced untoward incidents and complaints.
- Greater staff awareness of accountability.
- Better targeting of professional and educational development.
- Improved delegation.
- Increased innovation.
- Improved reflective skills.
- Reduced staff sickness.
- Improved staff retention.
- Enhanced input into management appraisal systems.

It is also essential to evaluate the process, including planning, implementation, evaluation systems and documentation. All those involved in the practice supervision process could complete an evaluation tool to assess its impact on the individual. There are several forms this might take such as interview, workshop, and questionnaire. The supervisee and supervisor can be asked whether practice supervision:

- Improves clinical practice.
- Effectively challenges working practice.
- Encourages planning of learning.
- Contributes to clinical and service development.
- Increases awareness of new areas of professional knowledge.
- Aids reflection on strengths/weaknesses.
- Assists in managing stress at work.
- Improves self confidence.
- Facilitates team working.

An audit of the process of practice supervision can involve gathering information from practice supervision contracts and practice supervision records. These can provide information on the types of models being used, pros and cons of support materials, frequency and duration of meetings, and reasons for cancellation of meetings. This data can be used to assess whether the process is working well. It does not include accessing the content of the supervision session.

See Appendix 11 for an example of an audit tool.

Taken from A guide to implementing clinical supervision The Chartered Society of Physiotherapy *(September 2005).*

1.10 Modes of Supervision

Within the framework of practice supervision there are a number of different modes of supervision. There will be situations where different modes work better than others:

1.10.1 One-to-one Supervisor/Supervisee

- One-to-one session with a supervisor who is experienced in the same discipline/area of practice. This is the most widely used method of supervision.
- One-to-one session with a supervisor whose experience is in a different area.

1.10.2 Group Supervision

- With a number of different supervisees, where one supervisor takes the lead or with a specific team of staff who have similar experiences – e.g. peer supervision. Supervisors should have appropriate group work experience in order to facilitate a group.
- With a number of different supervisees from different professions, where one supervisor takes the lead. Supervisor should have appropriate group work experience in order to facilitate a group.

1.10.3 Eclectic methods of supervision

- This is a combination of the above models.

See Appendix 2 for a breakdown of the strengths and weakness of the various approaches detailed above. There are other modes of supervision available that can be used to meet the needs of a service.

1.11 Practice supervision Process

1.11.1 Ground Rules

When setting up a supervision framework it is important to establish some ground rules first, so that all parties involved know where the boundaries are and what measures may have to be taken if the supervision process is not working.

1.11.2 Frequency

The frequency discussed below relates to formal practice supervision and is not about general day-to-day supervision of staff which will vary according to experience and grade of staff. Formal structured practice supervision should be held at intervals to suit the needs of the supervisee and supervisor. Please refer to your own organisation/professional body guidelines for frequency.

A minimum recommendation is at least once every two months. The workload management toolkit (BDA, 2004) refers to 45 minutes of supervision per week.

Obviously, this is a guide and does not have to exactly reflect the time spent on practice supervision, as this will vary according to the needs of the practitioner. This will be agreed when setting up your contract.

Staff requiring supervision through a presenting critical incident or emergency scenario should receive this within the framework of their day-to-day supervision process.

1.11.3 Confidentiality

A supervision contract needs to include a clear agreement about confidentiality. It is recommended that you are aware of your organisational policy on confidentiality during practice supervision sessions.

Issues brought to practice supervision should not be discussed outside the session unless agreed by the individual/group. Issues which may be taken outside the group may include those which require action by others e.g. where there is a serious concern about clinical risk, safety of practice, or breach of Code of Professional Conduct (BDA, 2008, HPC Standards of Proficency (HPC, 2007), HPC Standards of Conduct, Performance and Ethics (HPC, 2008).

Training or development needs may be identified through practice supervision and these can be brought to the appraisals meetings with the appropriate manager.

1.11.4 Recording and Documentation

The supervisor will hold the documentation. The supervisee will be provided with a copy of the documentation. The supervisor is responsible for ensuring practice supervision sessions happen and are recorded. All documentation should comply with BDA Guidance for Dietitians for Record and Record Keeping (BDA 2008).

1.11.5 Administrative support for practice supervision

Administrative support is a local issue and should be agreed prior to implementation of the process.

1.11.6 Termination

Either party may opt out of the supervisory relationship at any time, as the agreement is voluntary. It is advisable to discuss the relationship from time to time in order to evaluate it. If either party finds the session is becoming uncomfortable or unmanageable, it is advisable to stop the session and seek advice from line management. The supervisee should receive support until a new supervisor can be selected.

2. Tools to Support the Process

2.1 Supporting tools for Practice Supervision

Practice supervision can take many forms. The following tools may help you to develop your practice supervision sessions to be most effective. Everyone can develop supervision to meet their needs. These questions and ideas provide a starting point but are not meant to be prescriptive.

2.2 Practice Supervision Network Directory

In some organisations, practice supervision may be well established with a wide pool of supervisors to choose from. Arrangements for supervision should be made on a basis of need, which allows for flexibility of supervisors from the same profession or across professions and MDT teams.

If a supervision arrangement does not appear to be fulfilling an individual's needs this should be discussed and a new supervisor should be sought. To facilitate the process of matching a practice supervisor with a supervisee it may be helpful to set up a practice supervision network directory.

A sample form to help achieve this can be found in Appendix 3.

2.3 Setting Up Contracts

2.3.1 The supervision contract – content

A supervision contract is the most essential ingredient that underpins the supervisory relationship. The contract is a negotiated agreement which identifies ground rules about the supervision process.

The contract must be agreed between supervisor and supervisee and any exemptions to this agreement need to be firmly established from the outset. A contract should include the following:

- Essential details.
- Supervisee.
- Supervisor.
- Date of contract.
- Period of contract.
- Mode of supervision.
- Agree goals and outcomes.
- Practicalities.
- Frequency of sessions.
- Length of sessions.
- Venue.
- Procedure for changing a session.
- Acceptable reasons for cancelling a session.
- Punctuality.
- Review arrangements.
- Ethics and responsibilities.
- Code of ethics and practice.
- Issues of confidentiality.
- Responsibilities of supervisee.
- Responsibilities of supervisor.
- Agenda issues.
- Topics for inclusion.

See Appendix 4 for an example of a contract.

2.4 Environment

It is important that the environment for practice supervision is suitable to ensure the session is as effective as possible. Some examples of how this might be facilitated are detailed in Appendix 5.

2.5 Session Structure of Practice Supervision

The structure the supervision session will help the session to remain focused; an example of the type of structure using reflection that could be used is detailed in Appendices 6 and 7.

2.5.1 Setting the agenda for the session

It is important for the supervisee to consider what they wish to deal with in the time available. The supervisor may wish to identify how much time the two of you or the group have for this session. The supervisee will quickly understand the need for prior consideration of issues to bring to supervision. This will speed up the agenda setting as they will know what they want from the session with little prompting.

However, there are some specific points that the supervisor may wish to clarify.

2.5.2 What will be on the agenda today?

The main part of each session will involve the supervisee describing and discussing their work through the process of reflection.

2.5.2.1 Supervision Topic

Just some of the topics that you could identify include:

Routine and complex cases, critical incidents, clinical risk – what to do if you have made an error? Effective practice, integration within teams, supporting and delegating, empowerment, report writing, multi-agency working, and resource issues affecting practice. Practitioners also have a responsibility to take to supervision any difficulties, uncertainties or distressing aspects of their work.

Service managers may want to consider the following topics for their supervision agenda, i.e. challenging service work load issues, developing service policy, interview panels and HR issues.

2.5.2.2 Reviewing the work done since last session

It is essential that continuity is maintained between sessions. To help the supervisee in linking the supervision sessions directly to practice, it is useful to use the following type of questions to evaluate the effects of the previous session:

- What were the main issues we talked about last time?
- Were there any thoughts or feelings that you had about the last session?
- What was useful or not useful about the last session?
- What specifically did you decide to do after the last session?
- Is this what you did? If not what stopped you?
- How have you reflected on your work since the last session?
- Have you been talking to anyone else about the things we dealt with last time?
- If you have, did it help?

There are many secondary questions and other types of response that may need to be used to explore the answer to these questions. The main intention of this review is to provide information and discussion to orientate and focus both Supervisee and Supervisor at the start of the session. It will start the more formal work in the session.

2.5.2.3 Session review and orientation into the future

It is important to finish each session by paying attention to how the time has helped the supervisee in the reflective process. The session may not have provided all the answers, and may in fact have left the supervisee with even harder questions about their practice or personal issues. It can be productive therefore to identify these issues at the end of the session. Specific decisions relating to changes in practice and the need for practice development to take place before the next session can be identified. This will help at the start of the next session.

2.5.2.4 Action plan for next meeting

It is essential that an outcome-based action plan is developed between supervisee and supervisor and it is agreed and signed off at the end of each session.

2.6 Further tools to support the practice supervision session

2.6.1 Learning styles

It is important to understand both the supervisor's and supervisee's learning style to ensure the supervisor is able to support and empower the supervisee in a safe learning environment. This will facilitate the development and enhancement of future practice. Information on learning style questionnaires can be accessed at:

- www.PeterHoney.com/HoneyMumford
- www.vark-learn.com

2.6.2 Should you be a practice supervisor quiz

This will give an indication of potential to become a practice supervisor. See Appendix 8.

2.6.3 Supervision attendance and monitoring forms

A sample supervision attendance form and monitoring form are profiled in Appendices 9 and 10 respectively.

2.6.4 Supervision Audit

An example of an audit tool is available in Appendix 11.

Appendix 1 - Practice Supervision Action Plan

The following is a useful checklist for implementing practice supervision systems.

Stage	Action	Date achieved
Planning	Formal agreement is given by management on implementation of a practice supervision strategy. A practice supervision lead (individual or group) is appointed to work on implementing the scheme. Understanding of and interest in practice supervision is assessed among all staff (group workshop, questionnaire) to assist with future planning and training. Presentation of findings to management including: • Resource implications for implementing practice supervision. • Expected outcomes for staff, organisation and service delivery. Management commitment to next stage is required before moving to the next stage. Development of evaluation mechanism to gauge how effective practice supervision will be: what are the anticipated outcomes for staff, service users and organisation.	

Set-up	Presentation made to all staff on generic issues around practice supervision: definition; purpose; roles and responsibilities; process; outcomes. Practice supervisor volunteers are requested for training. Open to all appropriate staff. Training given to practice supervisors on required skills, knowledge and abilities. Relevant documentation is created to support the system, i.e. generic contracts, session records, action plans. All staff have access to a practice supervisor.	
	Practice supervision sessions commence	
	Follow-up training/support provided by lead as appropriate.	
Evaluation	Evaluation with all staff carried out at previously agreed review date: Individual's development and benefits evaluated: process of implementing and executing system evaluated. Review and improve documentation as appropriate. Evaluation. Present evaluation report to management and make recommendations for continuation of/alteration to system accordingly.	

Appendix 2 - Strengths and potential weaknesses

Of individual supervision

Strengths	Weaknesses
More time for supervisee.	Full focus on individual supervisee.
Opportunity to create clearer and more focused objectives.	Input from only one person (supervisor).
Highly personalised.	Difficulties if supervisory relationship breaks down.
Supervisee can work at own pace.	Evaluation and feedback from one person's perspective only.
Non-competitive environment.	Can become collusive with little challenge.
Allows supervisee to concentrate on one particular issue.	Can foster dependency in supervisees.
Development in supervision can be easily monitored.	Less comparison for supervisees re: other ways of working.
Supervisor's intentions can be geared specifically towards the learning of the supervisee.	

Of group supervision

Strengths	Weaknesses
Input from a number of people.	Individual's needs may not be addressed.
Supportive atmosphere from peers.	Individuals may get "lost" or "hide" within the group.
Values of listening to others describe their work and problems they face.	Maybe a lack of time for group members with large case loads.
Cost effective in time and economics.	Not all are suited to group work.
Can allow experimentation with other interventions.	Can be used as a "dumping ground".
Can help supervisees deal with issues of dependency on supervisors.	Group dynamics may temporarily impede the task.
Evaluation and feedback from a number of people.	Pressure to conform, "Group think".
Risk taking can be higher in a group setting.	Difficulty for newcomers to enter group.
Emotional support from peers.	Some topics may not be of interest to other group members.
Issues arising from within the group can be addressed.	Lessening of confidentiality.
Dilutes power of supervisor.	Overload for some members.

(Hawkins and Shohet, 1992,)

Appendix 3 - Directory form

Practice Supervision Network Directory

Name:	**Mode of Clinical Supervision (please tick one):** **Group** ☐ **One-to-one** ☐
Position:	**Are you willing to be a supervisor?**
Base:	**Other health professional to supervise:** **Name:** **Agreed: Y/N**

Summary of current job role:

Key Skills:

Areas of Interest:

Career history and personal profile:

(What you would like your colleagues to know about your career to date and you personally)

Office Use Only:

Supervisor/Supervisee

Appendix 4 - Practice supervision contract

Supervisor/Group Supervisor:		Designation:	
Supervisee:		Designation:	
Frequency:		Duration:	
Venue:		Procedure for changing a session:	
Ethics and responsibility:			
I will agree to be punctual to all supervision sessions			

Record Keeping:

Type of record to be kept, who will keep them and how the record will be used.

Where records will be kept, who will have access?

Confidentiality agreement: E.g. We agree that issues relating to Code of Conduct can be raised outside of the supervision session.	**Signatures:** Supervisor: Supervisee:

Purpose of Meetings:

The primary aim of Supervision is the welfare of patient/clients through the supervisees' learning process in terms of knowledge, skills, attainment, development and attitude refinement.

Goals for Supervision:

- To reflect on at least one area of practice during each practice supervision session.
- To achieve demonstrable developments in dietetic practice.
- To ensure quality in practice.
- To feel supported in practice.
- To share experiences and learn from each other to develop services and the individual.

Agreed to prepare items for discussion:	
Date for review of Contract:	

Appendix 5 - Practice supervision – the appropriate environment

Condition	Is this available?	What changes do you need to make?
Comfortable seating		
Appropriate room layout		
Acceptable level of background noise		
Avoidance of interruptions and distractions		
Access to appropriate refreshments		
Facilities for any special needs		
Privacy		
Easy access from place of work		

Appendix 6 - Supervision Record

Name: Date:
Agenda: Supervision Topics for this session: Review of Last session:
Issues discussed at this session:
Agreed action: e.g. What have I learned: What will I do differently:
Agreed action by supervisor:

Signatures: 1. 2.
Date of next supervision: Time: Venue:

Appendix 7 - Reflective practice (Gibbs, 1988)

1. DESCRIBE WHAT HAPPENED

Where did it occur?

What happened?

What was your role in the event?

2. ANALYSE WHAT HAPPENED

Why was it important?

Were there notable outcomes?

How did you feel?

What was satisfactory?

3. EVALUATE THE EVENT

Challenge your practice and knowledge.

What might have been done differently?

What have you learned?

What are your feelings now?

4. INFORMING FUTURE PRACTICE

What are the key learning points that must inform you future practice?

How will you make this happen?

Appendix 8 - Should you be a practice supervisor?

Answer Yes, Sometimes or No to each question

		Score
1.	Do you know what it is like to have worries concerns and frustrations about your work?	
2.	Do people seek you out to talk about their worries, frustrations and concerns?	
3.	Is the amount of time that you spend listening at least four times what you spend talking?	
4.	Has anyone in your life helped you uncover an aspect ability or talent of yours that, until then, had lain dormant and unrecognised?	
5.	Has anyone provided you with a quote that had great meaning to you, that influenced your thinking and behaviour, and that you sometimes pass on to others?	
6.	Has anyone provided you with an enlightening experience that enabled you to understand the meaning of some event, in someone, in something or in yourself?	
7.	Has anyone helped you to gain knowledge about how things work, about how things get done?	
8.	Has anyone encouraged you to find a way to deal with challenges in your life or work?	
9.	Has there ever been anyone in your life who had a profound positive effect on you, but you didn't realise it until much later in your life?	
10.	Has anyone provided just the right help to you at just the right time?	
11.	Has anyone helped you to grow and deepen your character, moral or ethical integrity or gain a stronger commitment to your values?	
12.	Has anyone inspired you to shift the direction of your life in a constructive way?	
13.	Have you ever reached out to another person who was in need and what you provided appeared to make a beneficial difference to that person?	

14.	Do other people reach out to you to assist them with important life or career decisions?	
15.	Have you ever had an experience where something you observed, read or experienced had a profound effect on your strengths and abilities?	

Add up your total score

Yes = 5 Sometimes = 3 No = 2

If your total score is between **60 and 75** you not only have potential to be a great practice educator, but you are probably already acting as a practice educator to several people.

If your total score is between **45 and 49** you are clearly valued and have experienced what it takes to be a practice supervisor.

If your total score is between **30 and 44** you have some strengths that can blossom into great supervisor opportunities.

If your total score is below **29** training and exploration may help you achieve your goal to become a practice supervisor.

Appendix 9 - Practice Supervision Attendance Form

Frequency of Contact: 2 monthly **Name of Group Facilitator/ Supervisor**:

Date	Session cancelled/missed (reason)	Content of Supervision Session						Duration	Signatures	
		Clinical Practice			Relationships		Support/ Restorative			
		Ind patient care	Procedural	Policy	Patient	Professional			Supervisor	Supervisee

Appendix 10 - Supervision monitoring form page ___of___

Frequency of contact: 2 monthly **Name of supervisee:** **Grade:** Band **Name of supervisor**:

Planned date	**Session cancelled (code)**	**Content**						**Type of Contact**		**Duration**	**No. of weeks between sessions**	**Signatures**	
		Manag-ement	Clinical			Professional		Face to face	Tele-phone				
			Group	*Indiv*	*Docu-mentation*	Devt	Support					*Supervisor*	*Supervisee*

Appendix 11 - Example of audit tool A

The audit of supervision should take after the sixth session as a minimum, or on an annual basis. The aim is to ensure that a high quality of supervision takes place within the service and reviews the standard and guidelines for supervision.

1. Service area:

   Please state clinical specialism:

2. Your grade:

   Band 2 ☐

   Band 3 ☐

   Band 4 ☐

   Band 5 ☐

   Band 6 ☐

   Band 7 ☐

   Other – please state……..

3. Have you received your copy of the supervision package?

   Yes ☐

   No ☐

4. Please rate the supervision package:

Very helpful □

Helpful □

Unhelpful □

Very unhelpful □

5. Have you ever had any training about supervision?

Yes □

No □

If yes, please specify:

6. How often is your supervision?

1 weekly □

2 weekly □

3-4 weekly □

5-6 weekly □

7-8 weekly □

Please state other: □

How long is your supervision for: _____

7. Are your sessions ever cancelled?

   Yes ☐

   No ☐

   How often?

   Why?

8. Is the environment suitable for your supervision sessions?

   Yes ☐

   No ☐

   Is the environment quiet?

   Yes ☐

   No ☐

   Is the environment free of disturbances?

   Yes ☐

   No ☐

   Is the environment private?

   Yes ☐

   No ☐

Is the environment within your locality?

Yes ☐

No ☐

9. Do you understand the boundaries of confidentiality?

Yes ☐

No ☐

Has it been discussed within your supervision sessions?

Yes ☐

No ☐

Do you think it is being adhered to?

Yes ☐

No ☐

10. Have you negotiated a supervision contract?

Yes ☐

No ☐

Is the contract written?

Yes ☐

No ☐

Were the aims defined?

Yes ☐

No ☐

Is a review date recorded for your contract?

Yes ☐

No ☐

Do you record your supervision sessions?

Yes ☐

No ☐

11. How do you rate the quality of your supervision sessions?

Very satisfactory ☐

Satisfactory ☐

Unsatisfactory ☐

Very unsatisfactory ☐

12. How have you benefited from the supervision?

13. Does your supervision cover the following areas?

Tick one or more

Support ☐

Challenging practice ☐

Reflection on clinical practice ☐

Regular feedback ☐

Professional responsibilities	☐
Management of self	☐
Clinical casework	☐
Development of clinical skills	☐
Career developments	☐
Managing stress	☐

14. Please add any other comments about Supervision or the Supervision Package:

Thank you for completing this questionnaire

Taken from NHS Lothian Occupational Therapy Supervision resource Pack (2007)

APPENDIX 12: Example of Audit tool B

Service area:

_____

Clinical Specialism:

_____

Please state grade:

Band 1 ☐ Band 2 ☐ Band 3 ☐ Band 4 ☐

Band 5 ☐ Band 6 ☐ Band 7 ☐ Band 8 ☐

Please consider pre-supervision preparation in this section:

1. Have you referred to the BDA practice supervision guidelines in preparation for your sessions?

   Yes ☐ No ☐

2. If Yes do you feel this information provides sufficient information to support your practice supervision?

   Yes ☐ No ☐

If No, what else would be helpful?

_____

3. Have you ever had any training about practice supervision?

Yes ☐ No ☐

If yes please specify:

_____

Please consider timing and frequency of supervision sessions in this section:

4. How often is your supervision?

Weekly ☐ Fortnightly ☐ Monthly ☐

Every 2 months ☐ Other: ☐

If 'other' please state: _____

5. Please rate adequacy of the frequency of your supervision

Adequate ☐

Inadequate ☐

If inadequate please state why: _____

6. If you feel frequency is not adequate please state your preferred option of frequency (please bear in mind BDA guidelines recommend a minimum of 6 sessions / year):

7. When does your supervision session occur?

   Morning ☐ Afternoon ☐

If the current timing of your practice supervision is unsuitable, please state why:

_____

8. Are your sessions ever cancelled?

   Yes ☐ No ☐

If yes, how often?

_____

Why? _____

9. Consider the following aspects of the environment suitability for your supervision?

	Significantly agree	agree	disagree	Significantly disagree
Quiet	☐	☐	☐	☐
Private	☐	☐	☐	☐
Free of disturbances	☐	☐	☐	☐
Ease of access (locality)	☐	☐	☐	☐

10. How long do your Practice Supervision sessions last?

0-30 mins ☐ 30-60 mins ☐ 60-90 mins ☐ 90+ mins ☐

12. Is the length of sessions satisfactory for you?

Yes ☐ No ☐

If not please indicate below how long you feel your sessions should last:

Please consider the type and make up of supervision session you have for the following questions:

13. Is your supervision?

1:1 ☐ Group ☐

14. If group how many Supervisee's are in your group?

2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐

15. Do you feel the number in your group is adequate?

If not, what number do you think would be preferable?

---

16. Are the other supervisees in your group:

All of the same banding? ☐ Mixed banding? ☐

17. Do you feel the dynamics of your particular group is effective?

Effective ☐

Not effective ☐

Please comment:

Please consider the structure and content of <u>your</u> particular practice supervision sessions when answering the following questions:

18. Have you negotiated a supervision contract?

Yes ☐ No ☐

19. Have you been provided with a copy of your contract?

Yes ☐ No ☐

20. Have you had the opportunity to review your contract?

Yes ☐ No ☐

21. If you haven't reviewed the contract yet, is there a review date agreed?

Yes ☐ No ☐

22. Do you understand the boundaries of confidentiality?

Yes ☐ No ☐

23. Have you discussed importance of confidentiality when planning the contract?

Yes ☐ No ☐

24. Do you think confidentiality is being adhered to within your group?

Yes ☐ No ☐

25. When considering the actual structure of your sessions do you feel they are effective?

Yes ☐ No ☐

If no please provide reasons:

_____

_____

26. What areas of Practice does your supervision cover? Tick one or more:

Support	☐	Challenging practice	☐
Reflection on clinical practice	☐	Professional responsibilities	☐
Clinical casework	☐	Management of self	☐
Career development	☐	Managing stress	☐

27. Have you presented anything within your supervision group?

Yes ☐ No ☐

If yes, was the outcome beneficial?

If No, What could have improved the outcome?

28. . Do you keep a record of your supervision sessions for your CPD portfolio?

Yes ☐ No ☐

29. Do you feel the paperwork supporting the documentation of supervision is adequate?

	Significantly adequate	Adequate	Inadequate	Significantly inadequate
Contract form	☐	☐	☐	☐
Register form	☐	☐	☐	☐
Session reflection forms	☐	☐	☐	☐

Please add any other comments relevant to Practice supervision within Cardiff and Vale Nutrition and dietetic service:

Thank you for completing this questionnaire

Taken from Cardiff & Vale NHS Trust, Nutrition & Dietetic Dept, May 2009

3. References

Butterworth, T. et al (1997). It is good to talk. An evaluation of clinical supervision and mentorship in England and Scotland. Manchester: University of Manchester.

Gibbs, G. (1988). Learning by Doing: A guide to teaching and Learning methods, Further Education Unit. Oxford: Oxford Polytechnic.

Hawkins, P. & Shohet, R. (1992). Supervision in the Helping Professions. Open University Press.

Health Professions Council, (2006). Continuing professional development and your registration. London: HPC.

Health Professions Council, (2008). Standards of conduct, performance and ethics. London: HPC.

Health Professions Council, H. P. (2007). Standards of proficiency. London: HPC.

The Open University, (1998). School of Health and Social Welfare Clinical Supervision; A Development Pack for Nurses.

The British Dietetic Association, (2008). Code of Professional Conduct. Birmingham: BDA.

The British Dietetic Association, (2008). Guidance for Dietitians for Record and Record Keeping. Birmingham: BDA.

The British Dietetic Association, (2005). Professional Standards for Dietitians. Birmingham: BDA.

The British Dietetic Association, (2004). The workload management toolkit. Birmingham: BDA.

4. Additional References

Bond, M. & Holland, S. (1998). Skills of Clinical Supervision for Nurses: Open University Press.

Cutliffe, JR., Butterworth. T., Proctor, B.,(2001). Fundamental Themes in Clinical Supervision. London: Routledge.

Fowler, J. (1998). The Handbook of Clinical Supervision – Your Questions Answered. Quay Books.

Hunter, EP. & Blair, SEE. (1999). Staff Supervision for Occupational Therapists. *British Journal of Occupational Therapy*, Vol 62(8) 344-350.

Johns, C. (2000). Becoming a Reflective Practitioner A reflective and Holistic Approach to Clinical Nursing, Practice development and Clinical Supervision: Blackwell Science.

Kolb, D. (1984). Experiential Learning: Experience as the source of learning and development. New Jersey: Prentice-Hall.

Ooijen, EV. (2000). Clinical Supervision A practical Guide. Churchill Livingstone.

Yegdich,T. (2006). Clinical Supervision and Managerial Supervision: Some Historical and Conceptual Considerations. *Journal of Advanced Nursing*, Vol30 (5) 1265-1204.

The British Psychological Society

Division of Clinical Psychology
Faculty for Learning Disabilities

Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to People with Learning Disabilities

August 2005

Purpose and status of this document

This document has been prepared by a working group on behalf of the Faculty for Learning Disabilities (formerly the Learning Disability Special Interest Group). Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the needs of individuals with learning disabilities, in whatever setting or context they come into contact with them. The guidance within is also intended to aid in planning and evaluating the consolidation of experience and competences of newly qualified clinical psychologists working within the learning disabilities speciality prior to transition from Agenda for Change band 7 to band 8. The Faculty believes that it is the responsibility of each training course in conjunction with local Special Interest Groups and supervisors to work jointly towards these aims and to use the present guidance to these effects. This is in line with the current Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology (CTCP, 2002) which set out clear requirements for consultation with DCP Faculties in relation to:

- 'the expected capabilities which a trainee should gain to fit them for work with specific populations and groups' (Section A6);
- provision of 'the reference information for the minimum supervised practice commensurate with competence in an area of work' (Section 7.2), and
- 'development of the syllabus' (Section 9.1.)

This document has been approved by the DCP Training Strategy Group (TSG) for publication and circulation by the DCP.

Prepared by a Working Party on behalf of the National Committee of the Faculty for Learning Disabilities. Published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.

Comments & queries to k.scior@ucl.ac.uk, Sub-dept of Clinical Health Psychology, University College London, Gower Street, London WC1E 6BT.

1. Introduction

Historically the needs of people with learning disabilities have largely been addressed by specialist learning disability services. Over the past few decades there have been major changes in that people with learning disabilities are now far more likely to continue to live with their families at least into early adulthood, to attend mainstream schools and to be active participants in their local communities. Under current government policies there is an increasing emphasis on 'mainstreaming' and a shift away from segregated services. The White Paper *Valuing People* (DoH, 2001) emphasises four key principles: rights, independence, choice and inclusion. As a result of these developments clinical psychologists are likely to meet people with learning disabilities across a wide range of specialities, such as Child and Adolescent, Adult Mental Health, Forensic, and Older Adults. Thus there is a need to ensure that practitioners in all specialities are well equipped to work with this client group and to know when a referral to specialist learning disability services is appropriate.
The role of psychologists within learning disability services is to work with users, advocates and carers in ensuring that the users' perspective is empowered. Psychologists work within learning disability services with a 'person-centred approach' (DoH, 2001) to ensure service-users' wants and needs are supported. The service-users' perspective is paramount at all times, including when working with advocates, carers, support agencies, and all aspects of multi-disciplinary working, and is central to any interventions suggested.

2. Accreditation Criteria for Training Programmes in Clinical Psychology

The Committee on Training in Clinical Psychology Accreditation Criteria (CTCP, 2002) state the following points which are of particular relevance to people with learning disabilities:

Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce planning requirements within the NHS. These requirements will be shaped in part by…national policies, as well as by evidence of recruitment problems (for example, vacant posts) paying particular attention to specialities which have recruitment difficulties. (Section B.2.5)

The DCP in its guidance on clinical psychology workforce planning (DCP, 2004) recommends staffing levels of a minimum of 4.0 wte clinical psychologists specialising in work with people with learning disabilities, headed by a Grade B, in an average size district of 250, 000. In many parts of the country staffing in learning disability services falls way short of these recommendations and the speciality has traditionally experienced significant recruitment problems. It is the Faculty's belief that training courses should encourage trainees to specialise in this area post qualification. As part of this responsibility, training courses should expose trainees to this client group and challenge possible misconceptions which may result from lack of exposure rather than other factors.

While it is appropriate that Programmes should differ in their emphases and orientations, they must all provide academic teaching relevant to the full range of client groups and a wide range of clinical methods and approaches. This will include teaching on…learning disabilities, sensory and physical handicaps. (Section 9.2)

The Accreditation Criteria further set out required learning outcomes. It is the Faculty's view that learning disabilities services typically offer a working context

which is particularly suited to enable trainees to develop the following learning outcomes specified in the accreditation criteria (although it is recognised that other services can also contribute to developing these learning outcomes):

Communication and Teaching (Section B.1.3.8):

- *Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication*
- *Preparing and delivering teaching and training which takes into account the needs and goals of the participants*

Service Delivery (Section B.1.3.9):

- *Understanding of consultancy models and the contribution of consultancy to practice.*

Clients (Section B.2.6.1):

- *Problems ranging from those with mainly biological causation to those emanating mainly from psychosocial factors;*
- *Work with clients with significant levels of challenging behaviour;*
- *Work with clients across a range of levels of intellectual functioning over a range of ages;*
- *Work with clients whose disability makes it difficult for them to communicate;*
- *Work with carers and families.*

Modes and type of work (Section B.2.6.3)

- *Work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems.*

3. Required competencies, experiences and service settings

The Faculty for Learning Disabilities has drawn up a list of competencies to assist training providers in ensuring that trainees have acquired the learning outcomes specified in the Accreditation Criteria and have at least a basic capability to meet the needs of people with learning disabilities, wherever they may come into contact with them in their professional practice. The competencies listed below are based on the national policy document *Valuing People* (DoH, 2001), more specific guidance issued for Scotland and Wales (Scottish Executive, 2000; Learning Disability Advisory Group Report to the Welsh Assembly, 2001) and the Accreditation Criteria (CTCP, 2002). It should be noted that some of these competencies are very specific to a learning disabilities context and thus are unlikely to be achieved in other areas (these have been marked *). Other competencies laid out below are of a more generic nature and may be met through work in other specialities.

3.1* An understanding of the history and current context of services for people with learning disabilities, including: historical constructions of 'learning disability' and the marginalisation and stigmatisation of people with learning disabilities, institutionalisation, normalisation and the social model of disability.

3.2* An understanding of current policies, particularly *Valuing People* (and their Welsh and Scottish counterparts, where relevant), and means of service delivery, including Inclusive Education, Person Centred Planning and Care Co-ordination.

3.3* An appreciation of the heterogeneity of people classified as having a learning disability and an understanding of classification and epidemiological issues.

3.4 The ability to work with people who may be very different from trainees and at high risk of social exclusion, together with the ability to reflect on such work and feelings evoked.

3.5* An understanding of the biopsychosocial model as it applies to this speciality, including an understanding of possible causes of learning disabilities, the interaction of biology and behaviour (including behavioural phenotypes), autistic spectrum disorders, and possible physical and mental health problems and disabilities co-occurring alongside learning disabilities (e.g. sensory impairments, early onset dementia).

3.6* An understanding of the impact of having a learning disability across the lifespan, which may include diagnosis and intervention during the childhood years, transition during late teenage and early adult years, adulthood and older age. Trainees should also develop some understanding of the potential impact on family and paid carers of caring for a person with learning disabilities.

3.7* An understanding of the different contexts which people with learning disabilities may be part of: the family, special and mainstream education in schools and colleges, daycare, supported living schemes and residential care, and specialist care settings, such as acute psychiatric and forensic settings.

3.8 Ability to communicate, both face-to-face and in writing, with people from across the whole spectrum of communication abilities, including individuals who are non-verbal.

3.9 An understanding of power differences between professionals and people who are marginalised or disempowered due to cognitive or communication deficits and how to address these in practice (e.g. minimising the risk of acquiescence).

3.10* Ability to adapt psychological assessments and interventions to the cognitive, communication, sensory, social and physical needs of people with learning disabilities and their carers.

3.11 Ability to complete a detailed functional analysis and translate the results into appropriate guidelines which are sensitive to the needs of those implementing them, as well as recognising common barriers to successful implementation.

3.12 Ability to develop multi-faceted formulations and interventions which take into account individual, systemic and organisational factors.

3.13 Ability to work with a range of service providers, including health, social services, education, the voluntary and private sectors.

3.14 An understanding of the potential vulnerability of adults from marginalised groups and knowledge of adult protection policies.

3.15 An understanding of capacity and consent issues and ability to obtain informed consent and, where this is not possible, ability to sensitively judge whether any psychological input is in the person's best interests.

4. Mechanisms for achieving these competencies

All clinical psychology training courses should ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 Academic Teaching

The Faculty believes that each academic programme should have a specialist learning disability component which covers knowledge and skills specific to work with people with learning disabilities, alongside teaching which integrates thinking about people with learning disabilities with other client groups in relation to specific clinical and contextual issues. Both specialist and integrated cross-speciality teaching which addresses the needs of people with learning disabilities should be developed and reviewed in regular consultation with the regional SIG (Learning Disabilities) to reflect the views and needs of the speciality at both local and national level. The Faculty recommends that each programme should cover the following areas as a minimum, either through specialist and/or integrated cross-speciality teaching:

- The history and current context of services for people with learning disabilities and current policies.
- An understanding of power differences between professionals and people with learning disabilities and how to address these in practice, and, where relevant, in research.
- A thorough understanding of the theory and practice of psychometric assessments.
- An understanding of current 'best practice' in establishing eligibility for learning disability services.
- An understanding how a range of therapeutic approaches, assessments and interventions may be adapted to the needs of people with learning disabilities and their carers.
- A detailed understanding of current perspectives on 'challenging behaviour'.
- An understanding of functional analysis.
- An understanding of autistic spectrum disorders, including current understanding of causes, clinical presentations and appropriate interventions.
- An understanding of a range of methods suitable for evaluating psychological work with people with learning disabilities.
- An understanding of capacity and consent issues and their implications for clinical practice.

4.2 Clinical Placements

The Faculty recognises that trainees may be able to acquire at least some of the competencies outlined above in a range of service contexts and with a range of client groups. However, it is the Faculty's belief that in order to be able to integrate their knowledge, skills and clinical experiences trainees should, wherever possible, gain substantial experience within the context of a learning disability service. Ideally this will be in the form of a dedicated learning disability placement. In considering any alternative arrangements to this model, clinical training courses and regional supervisors should jointly ensure that such arrangements will allow trainees to gain a thorough understanding of the context and heterogeneity as well as complexity of the client group.

Trainees' supervised experience should include the following wherever possible:
Substantive experience with people with learning disabilities with a mix of presenting problems and service settings. Trainees should be exposed to individuals from across the spectrum of learning disabilities, including individuals with severe and profound learning disabilities, across the lifespan. This work

should ideally include the following range and types of experiences:

- work relating to someone whose behaviour is constructed as 'challenging', ideally involving a comprehensive functional analysis;
- work relating to someone with an autistic spectrum disorder;
- work with a person with severe or profound learning disabilities;
- at least one detailed psychological assessment, which should include the use of formal measures (e.g. psychometric or functional assessment), and which should at least partly be completed directly with a person with learning disabilities;
- at least one direct assessment and intervention involving a person with learning disabilities;
- at least one assessment and intervention with family or paid carers; this could include indirect work with a staff team; and
- formal evaluation of the impact of a piece of psychological work, whether assessment (and feedback) or intervention.

The Faculty recognises that some high quality, yet very specialist placements, may not provide the range of experiences outlined above. It is intended that these recommendations should serve as an 'ideal' template to guide course staff, supervisors and trainees. The precise meaning of 'substantive experience' should be judged on an individual basis, bearing in mind that the entire training experience should enable trainees to demonstrate achievement of the learning outcomes outlined in Section 2 and to acquire the competencies outlined in Section 3. In some cases these may be acquired through work with quite a number of clients, in others through much more in-depth work with a few clients, supplemented by observation, discussion and reflection. The range and types of experiences outlined above are of course not mutually exclusive, but several may be addressed in in-depth work with the same individual or care system.

5. Review Process

These guidelines should be reviewed in 2009. At that point, if not earlier, CPD requirements will be considered, including the type of competencies and experiences which should be consolidated in the first 18 months post-qualification.

Service users were not consulted in producing these guidelines. There is increasing involvement of service-users in policy development and processes such as staff recruitment in learning disability services giving people greater power and choice. The involvement of service-users will be considered for the review in 2009.

References

Committee on Training in Clinical Psychology (2002). *Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology*. Leicester: BPS.

Department of Health (2001). *Valuing People: A new strategy for learning disability for the 21st century*. London: The Stationery Office.

Division of Clinical Psychology (2004). *Guidance on Clinical Psychology Workforce Planning. DCP Information Leaflet No 6*. Leicester: BPS.

Division of Clinical Psychology Special Interest Group (Learning Disabilities) Task Group (1998). *Core Competencies for People with Learning Disabilities Experience and Teaching*. Leicester: BPS.

National assembly for Wales Learning Disability Advisory Group (2001). *Fulfilling the Promises: Proposals for a Framework for Services for People with Learning Disabilities*. Report to the National Assembly.

Scottish Executive (2000). *The Same as You? A Review of Services for People with Learning Disabilities*. Edinburgh: Scottish Executive.

Appendix 1: Members of the Working Group

Karen Dodd, Head of Psychology, Surrey Oaklands NHS Trust

Nan Holmes, Senior Clinical Tutor, Surrey Doctorate in Clinical Psychology

Rosemary Jenkins, Senior Clinical Tutor (Learning Disability), South Wales Clinical Psychology Doctorate

John Rose, Lecturer & Curriculum Co-ordinator, Birmingham Postgraduate Course in Clinical Psychology

Katrina Scior, Lecturer, University College London Doctorate in Clinical Psychology; Clinical Psychologist, Newham Primary Care Trust
(Chair of Working Party)

Appendix 2: Consultation Process

An initial draft of this document was circulated in June 2004 to the following:
National Committee of the DCP Faculty for Learning Disabilities
All S.I.G. (Learning Disabilities) regional groups
Group of Trainers in Clinical Psychology (GTiCP)

Comments on this draft were received from training providers attached to clinical psychology training courses, supervisors and convenors of learning disability teaching. Wherever these suggested a consensus or were based on convincing arguments they have been incorporated into this final document.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 252 9568 Fax: 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

Division of Clinical Psychology

The British Psychological Society

Continuing Professional Development Guidelines

December 2010

Contents

Cost:
Printed copies: DCP Members: £3.75; Society Members: £5.00; Non Members: £6.00.
Online copies: DCP Members: Free; Society Members: £3.52; Non-Members: £4.70.

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 254 9568; E-mail: P4P@bps.org.uk.

Printed and published by the British Psychological Society.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Telephone: 0116 254 9568 Facsimile 0116 227 1314
E-mail: mail@bps.org.uk Website: www.bps.org.uk
Incorporated by Royal Charter Registered Charity No 229642

Foreword

Continuing Professional Development (CPD) has the dual purpose of helping psychologists to maintain and enhance their professional skills whilst also maintaining public confidence in the profession.

Between October 2005 and October 2008 all chartered psychologists who held a practising certificate were required to submit an annual record of the CPD undertaken by themselves as a way of providing evidence of maintaining professional competence and reflecting on the learning that took place. The British Psychological Society (the Society) and the Division of Clinical Psychology (DCP) developed guidance for CPD for all clinical psychologists reinforcing the idea that both formal and informal CPD activities should be part of the psychologist's professional life and in keeping with the Service Objectives.

On 1 July 2009, the responsibility for monitoring and assessing CPD transferred from the Society to the Health Professions Council (HPC) who is now the statutory regulator of all practising psychologists. Undertaking both a necessary and sufficient range and depth of CPD is now central to the revalidation and re-registration process for all practitioner psychologists registered with the HPC. Whilst the HPC has its own guidance on CPD this document addresses wider contexts and professional issues beyond meeting the requirements for re-registration.

CPD and its impact on one's repertoire of knowledge and skills on everyday clinical practice remains a core function and responsibility of all clinical psychologists. As past Chair of the DCP CPD Sub-committee I am very happy to endorse these revised CPD guidelines. I would like to thank all of the members of the Sub-committee, particularly Brenda Roberts, for drafting and developing this document.

Professor Zenobia Nadirshaw
Past Chair, DCP CPD Sub-committee

1. The Government's position on life-long learning

The accelerating rate of change in modern societies has a number of consequences. Among them is a need to redefine the role of education and training. However long and thorough is the process of initial professional training, it can no longer serve to prepare individuals adequately to carry out their professional duties for the rest of their careers. It is in acknowledgement of this situation that the Government of the UK has supported the development of the concept of 'life-long learning'. This emphasises the need for all of us, at every stage of our careers, to take part on a regular basis in activities and processes, which will enhance knowledge and skills, deepen understanding and maintain best practice.

1.1 The statutory regulation of professions: HPC

The Society has for many years supported the introduction of statutory regulation for psychologists who offer their professional services to the public. This regulation became the responsibility of the Health Professions Council (HPC) from 1 July 2009. Professional title(s) became legally protected and it will be an offence to use those titles if you are not on the HPC register. Regular updates from the Society's President about issues relating to Statutory Regulation are posted on the Society's website:
www.bps.org.uk/the-society/statutory-regulation

Chartered Clinical Psychologists with either current or previous DCP membership were automatically transferred to the HPC register when Statutory Regulation was introduced but individuals who are not Chartered will have to apply direct to the HPC for individual scrutiny of their qualifications and experience to determine eligibility for registration. Further information about the HPC's registration and CPD requirements is available on their website: **www.hpc-uk.org**

1.2 What is CPD?

The Health Professions Council define CPD as 'a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.'[1]

[1] Health Professions Council: **www.hpc-uk.org/registrants/cpd/glossary/**

1.3 Identifying and meeting the costs of CPD: The balance of responsibilities

All applied psychologists, irrespective of employment context should have the opportunity to engage in CPD activity and should enjoy a measure of protected time from their employers to do this. The Society currently recommends a minimum of 40 hours of recorded CPD per year. This is considered to be the minimum amount of CPD time needed for an individual to keep up-to-date and maintain their professional competence and applies to all practising chartered psychologists irrespective of the number of hours worked. Those working full-time would be expected to undertake considerably more CPD activity than the minimum and the DCP advises a 70-hour minimum for those working full-time. Some of this time should be employed time but the Society and the DCP recognise that the individual also has responsibilities both to undertake and record CPD each year. Therefore, some agreement with employers and managers over study leave and time should be entered into which balances the individual's need to undertake CPD and the organisation's need for a skilled and competent workforce.

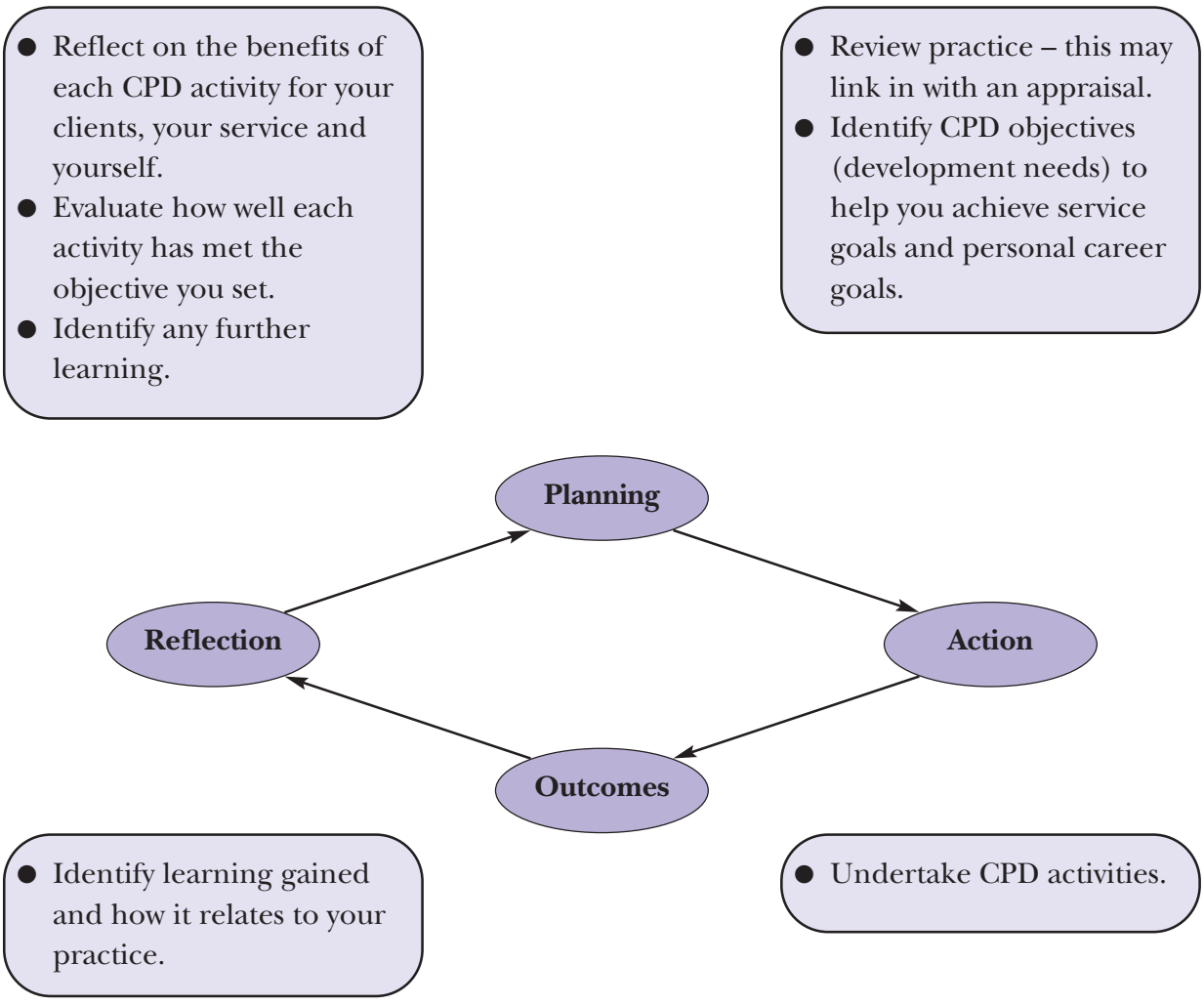
2. The Society Context

2.1 The Society's approach to CPD

CPD is seen as an integral part of psychologists' working lives, enabling us to keep up with the changes in the evidence base, technology and skill requirements as well as to enhance our professional skills and careers.

The model of CPD preferred by the Society is a cyclical one with four stages: Planning, Action, Outcomes and Reflection. In order to get the most out of CPD it is important to engage in the whole cycle with a focus not just on inputs, but, on outcomes and reflective evaluation, both the application of learning to practice and the identification of what has been learned through practice. What is required is a consideration of the effects of these actions on professional practice and some reflection on the whole experience.

CPD Cycle



Getting the most out of CPD

For most people, engaging in CPD involves undertaking a range of formal and informal activities, which necessitates an investment in time and money. Whether you are employed or an independent practitioner, it is likely that you will need to justify the resources you have committed to CPD by identifying the benefits gained. The following 'good practice' pointers are intended to help you make the most out of your investment in CPD.

CPD plan

Carrying out a review of your own practice, on at least an annual basis, is a good starting point for planning your CPD. For many clinical psychologists this will link in with an employer appraisal and the process of producing a personal development plan. In addition you may have some areas that you wish to develop in order to progress personal career goals. Thinking about what you need to update (e.g. new developments in your field of expertise, changes in legislation) and the particular areas that you want to develop can help you to clarify your goals for the year ahead. This will help you to identify and prioritise your objectives for CPD for the year and to start planning the most appropriate activities to achieve the updating/new learning that you need.

For many there is likely to be a significant amount of CPD that is undertaken as the year progresses, in response to work for clients (e.g. researching a particular topic or learning a new technique). Whilst these learning needs may not have been identified when you carried out your review, your plan is a living document and can be adapted as the year progresses, to include new learning needs as they arise. There are also likely to be some opportunities for CPD that arise serendipitously, for example, a conference or workshop on a topic of interest, and reference to your CPD plan can reconfirm your objectives and help you decide which would be the most appropriate use of your time an resources.

CPD activities[2]

CPD can encompass a broad range of activities, both formal and informal. It is important to remember that most psychologists are engaging in many of these activities as a normal part of their professional life.

A list of CPD activities can be found on the HPC website: **www.hpc-uk.org/registrants/cpd/activities**.

The balance of activities undertaken is likely to vary at different stages in your career. It is important to remember that the focus of activities should be upon the learning outcomes and how these are enabling you to develop and grow professionally.

Employers of applied psychologists, including the NHS, may set up programmes of mandatory training. Attending these may serve an important regulatory or governance function. However, such activities do not automatically belong in your CPD log unless they are linked meaningfully to your development needs and you can show how your practice has benefited from them. Your CPD log is not a record of adherence to your conditions of employment but a record of how you personally have sought to enhance your professional skills, knowledge and practice.

[2] For a list of CPD activities please see the Appendix on page 19.

CPD Reflective Evaluation and Learning Outcomes

The important outcome for each individual is what you have learned as a result of undertaking a particular CPD activity. The aim of reflection is to identify what has been learned and how this learning has been used, or will be used. You may wish to consider:

- Whether the activity has been successful and has met the relevant professional development need.
- How your knowledge skills and/or understanding has changed.
- Whether your perspective or approach has changed in any way.
- How it has helped you to develop in relation to your professional activity.
- What you can do that is different.
- The benefits that this has for your clients and your service.

Reflecting upon how you have applied/will apply the learning to your practice can help you to evaluate how well each of your CPD activities has met your expectations, and to identify the types of activity from which you have achieved most benefit. You may also find that the process of evaluation throws up some new learning objectives, together with some that have only been partially met, and these can be carried forward to your next phase of CPD planning.

2.2 Statutory Regulation for Psychologists and the Society's CPD Policy

The onset of statutory regulation means that the independent regulator will take on the role of regulating the CPD of practising psychologists, but alongside this there is still an ethical obligation for members to comply with the Society's CPD policy, which means engaging in and maintaining a reflective record of their professional development activities throughout their careers. The Society strongly recommends that members maintain an ongoing reflective record of their CPD.

2.3 Society support for CPD

It should be noted that whilst the HPC takes on the regulatory function, it does not take on a development function and so the role of the Society to promote good CPD practice amongst its members by providing guidance, training and support for practitioners remains. The Society provides a CPD online system as an aid to planning and recording CPD:

- The online facility for planning and recording your CPD is available at: **www.bps.org.uk/mycpd**

In addition the Society's Learning Centre is the main source of information on CPD opportunities for members: **www.bps.org.uk/learningcentre**

If you have any queries or require any additional information about CPD please contact the CPD helpline: Tel: 0116 252 9916 (Monday – Friday, 9.00 a.m. – 5.00 p.m.) or e-mail: cpd@bps.org.uk

2.4 Code of Ethics and Conduct

Under the terms of its Royal Charter, the Society is required to maintain a Code of Conduct. The *Code of Ethics and Conduct* produced by the Society's Ethics Committee in 2006 should guide all members in their professional practice and relationships. The code is based on four ethical principles, which constitute the main domains of responsibility within which ethical issues are considered. These are:

- Respect;
- Competence;
- Responsibility;
- Integrity.

Each ethical principle is described in the *Code of Ethics and Conduct* in a Statement of Values, reflecting the fundamental beliefs that guide ethical reasoning, decision-making and behaviour. Each ethical principle described is further defined by a set of standards setting out the ethical conduct that the Society expects of its members.

In planning, completing and recording CPD activity the Society expects all its members to observe this Code: **www.bps.org.uk/the-society/code-of-conduct**

In addition the Society has a declaration of human rights concerning torture and other cruel, inhuman or degrading treatment or punishment: **www.bps.org.uk/media-centre/press-releases/releases$/2005/declar.cfm**

2.5 Equal Opportunities and Diversity Issues

All large populations will contain individuals who vary along many dimensions. Cultures may view these variations with delight, tolerance or malevolence. In the view of the Society, the four ethical principles in the preceding section should form the foundation for psychological services offered to all, and should not be restricted or curtailed in any way because of variations of such characteristics as diagnosis, age, ethnicity or sexuality.

At all levels of work, from large-scale service planning to the details of service delivery, psychologists must work in partnership with the intended users of the service as well as with other stakeholders, in order to bring as wide a range of viewpoints as possible to the planning and setting up of services.

For those psychologists working within the NHS, it should be noted that the Knowledge and Skills Framework (see Section 3.1.4 below) identifies Equality and Diversity as one of the six core Dimensions that all NHS staff must address.

All psychologists need to continue to develop cultural competencies through familiarisation with other world views relating to all aspects of psychological functioning, including mental health, disability, and gender roles.

Applied psychologists face many challenges concerning equal opportunity and diversity issues in their work settings and in their professional practice. Some of these challenges are as follows:

- Promoting a culture of equality and universal human rights;
- Delivering positive psychological outcomes for disempowered and disenfranchised groups of people;
- Offering sensitive and appropriate services which meet the needs of individual clients rather than the systems in which those services are embedded;
- Developing service or business plans and professional practices that incorporate the ethos and philosophy of positively valuing difference and diversity;
- Working through prejudiced attitudes and belief systems;
- Being open and explicit in situations where there are conflicting belief systems among individuals or groups and having robust systems for supervision and reflection in order to establish and maintain best practice.

It is beyond the scope of this document to identify or recommend ways to deal effectively with the many dilemmas raised by issues of diversity, as they touch on some of the differences between groups and peoples that cause the most profound difficulties and conflicts to humankind. All we can do here is encourage transparency and respect for difference and advise that training in these matters is an ongoing need, whilst acknowledging the depth and complexity of the psychological, spiritual, political and moral responses that these situations evoke.

2.6 Leadership, Mentorship and Supervision

Leadership is pertinent to all stages of a clinical psychologist's career and is not limited to psychologists occupying supervisory or management positions. Increasingly, and certainly within the NHS leadership opportunities will be available post-qualification onwards and the Division will be developing leadership programmes to facilitate this. Some courses already exist for those contemplating Consultant grade and the Division would wish to encourage members to include leadership development within CPD plans. Sometimes this may include reading or locally-based management courses which can help prepare members for later job demands. Developing consultancy and mentoring skills should also be considered as a career long process.

Continued Professional Supervision for a range of health professionals lies at the heart of a string of NHS strategic documents. Equally the Society and the DCP have produced policy documents which require supervision to be organised for all levels and grades of experience. Supervision should be available for all aspects of professional practice, including management and training. Members completing CPD logs should record received or conferred supervision as a CPD activity in order to demonstrate the links between ongoing professional practice, the supervision process and their continuous learning outcomes.

3. The Divisional Context

3.1 Within the NHS

3.1.1 Governance

'Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.'[3]

CPD supports the delivery of high quality care and clinical governance. *A First Class Service* (DH) defined CPD as a process of life-long learning which meets the needs of patients and delivers health outcomes and priorities which enables professionals to expand and fulfil their potential.

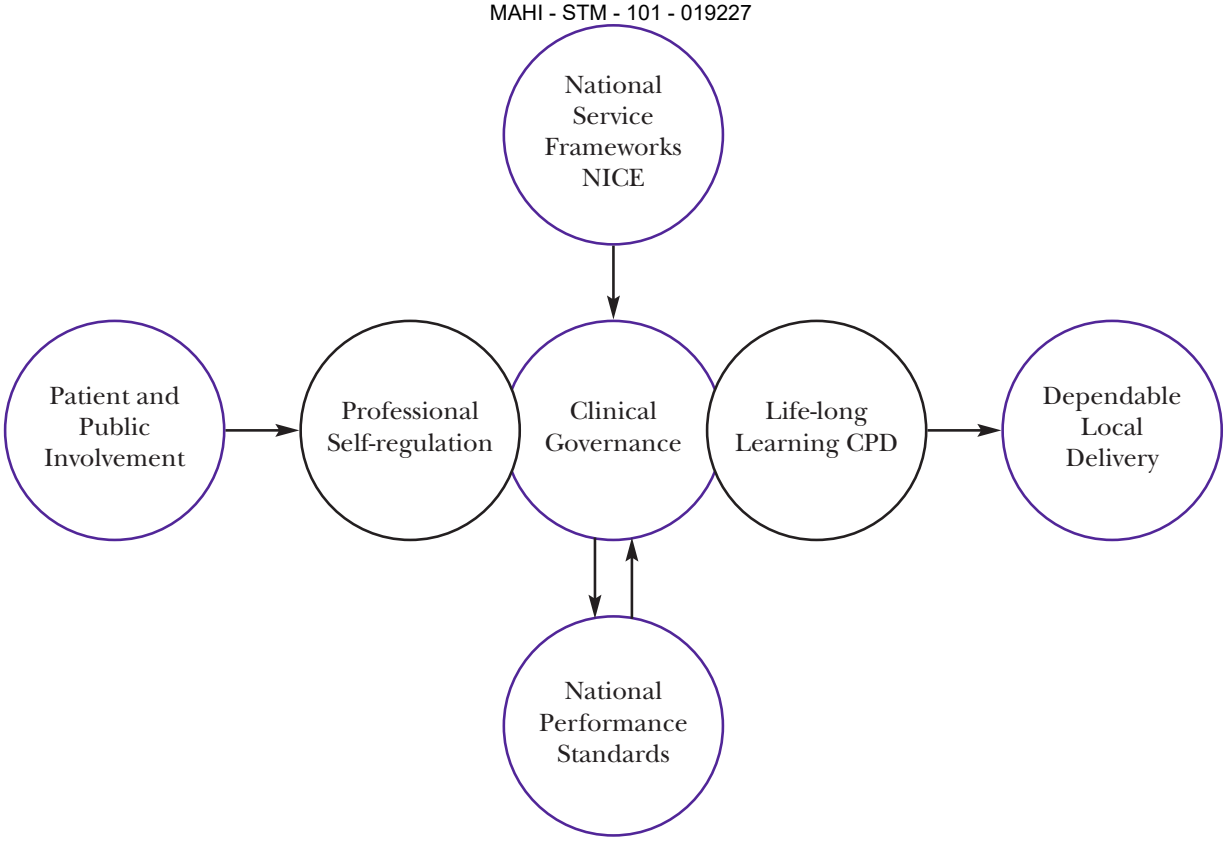
Governance refers to information recording and storage systems as well as to clinical care. Clinical psychologists must remain appraised of local, national and professional guidance and requirements concerning record keeping and systems for ensuring that the information they record and store is accessible only to appropriate others.

Trusts will vary in their governance structures and requirements. There may be advisory bodies or policy-making bodies for particular forms of work (e.g. CBT), for particular professional groups (e.g. psychological therapists) or for particular work settings (e.g. acute inpatient units).

All qualified clinical psychologists need to identify the governance arrangements relevant to their own working situation and satisfy themselves concerning the adequacy of their lines of access to these arrangements (including the adequacy of any proposals for dealing with conflicts of governance requirements from different bodies).

Participation in the development, implementation and monitoring of governance policies and procedures is highly recommended and is likely to provide many opportunities for CPD.

[3] Department of Health:
www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4006902



3.1.2 Multidisciplinary Teams and Partnership Working

All individuals, groups and teams working in health care settings can be expected to hold certain core values in common with each other. In addition, each discipline, group or profession will have its own particular contribution to make. Between the common ground and the particular approach there is space for either conflict or creativity. More recently, psychologists have begun to find themselves working with groups other than fellow clinicians to plan or deliver services. These may include service user and carer groups, commissioners and other less familiar stakeholders.

Among professional bodies of knowledge, psychology is best placed to encourage the exploration of shared assumptions, the identification of incompatible belief systems and the development of appropriate strategies for teams to genuinely work together such that differences are respected, valued and seen to contribute to multifaceted client care.

Developing and maintaining the skills, confidence and authority necessary to usefully apply this psychological knowledge in the workplace is a CPD need for all qualified clinical psychologists working in teams of all kinds.

Useful documents from the DCP include several authored by Professor Steve Onyett. These documents can be found on the Society website on the Professional Practice Board pages: **www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/**

Other useful references appear in Section 4 of this document.

3.1.3 Agenda for Change

This process applies to all directly employed NHS staff except very senior managers and those covered by the Doctors and Dentists Pay Review Body. Apart from these exceptions, all job descriptions and person specifications are now matched against national Job Evaluation (JE) profiles and allocated a pay band.

Psychologists may be employed from band 4 (psychology assistant) to band 9 and, rarely, beyond. Trainee clinical psychologists are employed on band 6 and may normally expect to be appointed at band 7 once qualified.

This may be under a preceptorship arrangement, such that with appropriate CPD over a specified period (usually not less than 18 months and probably nearer three years), upgrading to band 8a may be available. However, the move from band 7 to 8a should not be assumed and is only likely to occur if the post is established at 8a, with the explicit possibility of a newly-qualified clinical psychologist being offered the post initially as a preceptorship.

The additional competencies to be developed during this period will most probably relate to two of the AfC factors on the JE profile, namely Knowledge, Training and Experience (factor 2) and Freedom to Act (factor 8). The precise means by which the required additional competencies will be developed must be agreed from the outset with managers and employers.

Increasingly, clinical posts even up to band 8b are being advertised generically so that applicants may come from a wide variety of professional backgrounds. In order to compete successfully in this situation, it is essential that we become familiar with describing our practice in terms of the competencies we have, rather than the qualifications we have. Over a period, the CPD log may be of help in this process, if the reflective evaluation and learning outcomes sections of the log are written with this need in mind. Being explicit about how CPD activity will feed back into practice is a good way of clarifying which professional competencies we are attending to.

The emphasis on competencies, rather than on qualifications, is increasingly an element of training programmes in all professions, including clinical psychology doctoral programmes. The KSF process (see below) is the means by which Trusts will assess competencies, and all NHS clinicians need to be familiar with it.

Movement between bands, unless as above an 8a post is offered on band 7 as a preceptorship, is highly unlikely. In most cases, changing bands will mean changing jobs.

However, there is another particularly important boundary between 8b and 8c which marks the transition to consultant status. Preparing for this will be a serious undertaking which is a legitimate CPD focus.

3.1.4 Knowledge and Skills Framework (KSF)

The KSF defines and describes the knowledge and skills which NHS staff need to apply to their work in order to deliver quality services. It provides a simple, consistent, comprehensive and explicit framework on which to base review and development of all staff, including psychologists.

All NHS posts should have a KSF outline which defines the knowledge and skills needed

for the satisfactory performance of the tasks relevant to the post. There are 30 dimensions which together identify the total number of broad functions required by the NHS to enable it to provide a good quality service to the public. Each dimension has four levels. Six dimensions are common to every post, and must be used in every outline.

However, Trusts vary in the number of additional dimensions assigned to the outlines for different posts, in the level of performance assigned to each dimension, and in the detailed descriptions (called applications) of the tasks and duties in question.

This variability means it is difficult to compare a KSF outline from one Trust with one from another. Even if the same dimensions, at the same levels, are used, variance in the applications may make the jobs very different.

It is, therefore, essential that postholders know the dimensions, the levels and the applications in their KSF outlines so that gaps in required knowledge and skills can be clearly identified and plans made to close those gaps.

The KSF outline is used to define the initial (gateway) set of competencies needed in the early stages of performing a particular role, and also to define the full set of competencies needed to perform the same role at a higher level of competence. Increased competence, as measured on the KSF outline for the post, will result in the postholder moving up the pay band towards the next gateway.

In some services or localities the KSF fullset outline for posts on a given band may be adopted as the gateway KSF outline for the level above. However, because of the variabilities in applications, in levels and in dimensions even in similar jobs, KSF cannot always be used as a way of demonstrating preparedness for a new post or a higher band.

The British Psychological Society/Amicus Family of Psychology published *Life-long Learning and the Knowledge and Skills Framework for Applied Psychology* in June 2005, that set out KSF profiles for:

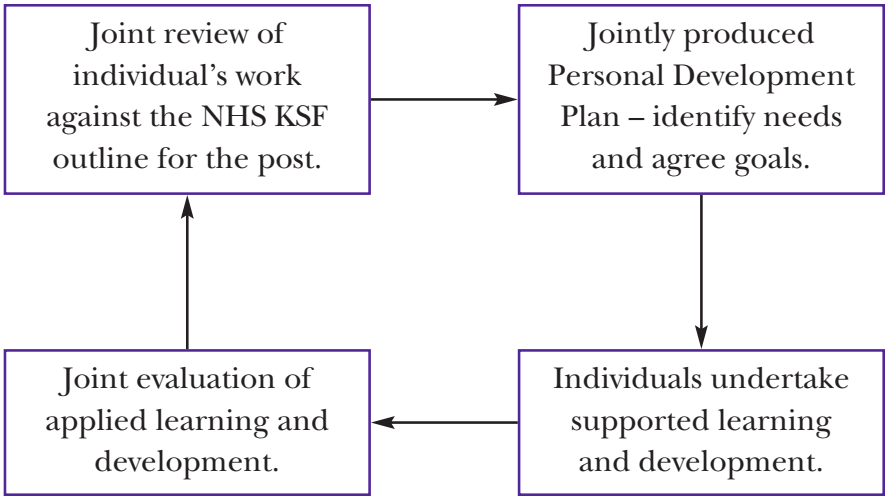
Clinical Psychology Assistant Practitioner	AfC Band 4
Clinical Psychology Assistant Practitioner Higher Level	AfC Band 5
Clinical Psychology Trainee	AfC Band 6
Clinical Psychologist	AfC Band 7
Clinical Psychologist Principal	AfC Band 8a-b
Clinical Psychologist Consultant	AfC Band 8c-d
Clinical Psychologist Consultant, Professional Lead/Head of Psychology Services	AfC Band 8d-9

It should be noted that although all posts should have gateway and fullset KSF outlines, Trusts are under no obligation to take note of these particular recommendations. The six core dimensions must be used, but beyond that Trusts are free to decide which competencies they require.

The Society's myCPD online planning and recording system enables users to record their CPD activities against appropriate KSF levels and dimensions. Only those dimensions which were used in the BPS/Amicus profiles referred to above will be available, but these should cover the majority of NHS Psychology posts.

3.1.5 Development Review Process – PDPs

NHS KSF forms the basis of a developmental review process. This is an ongoing annual cycle of review, planning development and evaluation for all NHS staff which links organisational and individual development needs.



Development is informed by looking at the individual's own learning and development needs against the requirements of the post as set out in the post's KSF outline. Each postholder should have their own Personal Development Plan based on their own strengths and learning needs. This, in turn, can be used as the basis for a CPD Plan.

It should, however, be noted that these documents have overlapping but distinct purposes. The CPD Plan is designed by the individual clinical psychologist, and whilst this will undoubtedly be heavily influenced by the individual's current work situation, it may also refer to future career planning (e.g. preparing for consultant posts or investigating the possibility of new kinds of role development such as becoming a Responsible Clinician under the new Mental Health legislation) or professional aspirations beyond the workplace (e.g. investigating the possibility of writing psychology books).

In contrast, a PDP will be service-focussed and possibly confined to annual discrete goals. It will probably be derived from the clinician's KSF outline. It is to be hoped that the preparation of each will be informed by the other so that where appropriate material from one may be easily imported into the other. However, the PDP is more likely than not to address service goals, which are achieved or not as the case may be. Personal reflections on learning may not be relevant or welcome in such documentation. Whatever the service outcomes, your own learning (and how it might affect your future professional behaviour) is what is important in your CPD Plan and Record.

3.1.6 New Ways of Working

New Ways of Working describes a whole systems approach to work force planning and development which is endorsed by all NHS professional bodies including the Society.

Recent policy guidance has concentrated on enhancing effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts.
For example, see: **www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/ppb-activities/new_ways_of_working_for_applied_psychologists.cfm**

The Multidisciplinary Teams focus on users and carers and are expected to change in structure and practice to provide an improved service.

The Creating Capable Teams Approach (CCTA) is a five-step approach developed to support the integration of NWW and the new roles into the structures and practices of an MDT within existing resources. The process helps a team reflect on function, the needs of service users and carers, the current workforce structure and the current and required capabilities. See DoH Mental Health. NWW. Developing and sustaining a capable and flexible workforce: April 2007:
www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/DH_074106

The importance of leadership in its several forms (Management; Clinical Leadership; Professional leadership; Team leadership) is emphasised and there can be several leaders for different purposes operating simultaneously. NWW promotes a culture shift in how practice in a team will manifest itself. See NWW – Implementation Guide – consultation paper, April 2007. Care Services Improvement Partnership:
www.newwaysofworking.org.uk/pdf/igapril2007.pdf

NWW promotes a model where responsibility is distributed amongst team members. The aim is to achieve a cultural shift enabling those with the most experience and skills to work face-to-face with those with the most complex needs and to supervise and support other staff to undertake less complex, and more routine work. This enables qualified staff to extend their practice, for example, non-medical prescribing and provides opportunities for new roles for example, Assistant Practitioner and PC MH workers.

Learning and development is a key function for effective implementation when extending roles and practice which this takes place in the context of service developments. The NMHE National Workforce Programme has produced a learning and development toolkit (DH publication Ref. 280397), setting out learning and development issues and priorities. It outlines contemporary guidance and available learning materials. These include the ten essential shared capabilities, as well as a range of other learning and development materials that are becoming available.

Some of the key principles underpinning NWW are highly relevant to CPD. These include:

- frequent reviews and annual appraisals linked to PDPs and AfC processes;
- provision of appropriate competencies for roles, training and supervision, which are essential to enable people to feel confident to take on and support others in NWW;
- formal arrangements that support profession-specific development to enable practitioners to feel confident in working differently;
- regularly updated advice from professional and regulatory bodies to members and registrants about NWW and on responsibility and accountability.

3.2 Other Professional Issues

3.2.1 Developing ourselves and others

At every career stage, clinical psychologists have some responsibility for assessing their own learning needs within the context in which they are working, and identifying some of the ways in which those learning needs may be met. We should also be prepared at every career stage to contribute to the development of other people. Formal teaching and clinical supervision are traditional and obvious ways of doing this. There are also plenty of other noteworthy ways of developing ourselves in the course of promoting the development of others, for example:

- newly-qualified clinical psychologists may mentor psychology assistants or trainee clinical psychologists
- training courses often have possible useful roles available in selection, interviewing, marking, mentoring, research supervision and participating in key course committees
- clerical, administrative and managerial colleagues may find great interest and benefit from the opportunity to discuss the psychological aspects of their work.

3.2.2. Developing teams, services and cultures

Clinical psychologists may find themselves embedded within a team, or invited to function as an external consultant, or placed somehow on the threshold, as it were, partly in and partly out of the team. This can be ambiguous and, perhaps, uncomfortable.

The discomforts of such threshold positions require appropriate management (perhaps through supervision or mentorship) but should not dissuade us from using the creative potentials available within such positions.

Beginning from our initial training in a number of different therapeutic modalities, clinical psychologists can be expected to have high-level skills in managing competing perspectives and tolerating ambiguity.

Such skills may have relevance at all levels of service planning and development by encouraging working groups and teams to explore and value differences and contrasts among them, and permitting the emergence of innovation.

3.2.3 Developing the profession

Since its establishment as a profession in the 1950s, clinical psychology has undergone a number of changes. The extent and pace of change is unlikely to slow in the foreseeable future.

All psychologists can and should take an active role in helping to ensure that the core values of the discipline are articulated and maintained while remaining flexible in the way those values are put into action.

Technological and social changes face us all with challenges and opportunities which will not have been intended or predicted. As psychologists we should remain alert to developing ways of tracking the effects of these changes, and understanding their implications for our knowledge base, our theories and our practice.

4. Further Information

Golding, L. & Gray, I. (2006). *Continuing Professional Development for Clinical Psychologists: A practical handbook*. BPS Blackwell.

Ovretveit, J., Mathias, P. & Thompson, T. (2007). *Interprofessional Working in Health and Social Care*. London: Palgrave Macmillan.

Payne, M. (2000). *Teamwork in Multiprofessional Care*. London: Palgrave Macmillan.

5. Bibliography

Health Professions Council: *Glossary of Terms.*
www.hpc-uk.org/registrants/cpd/glossary/

Health Professions Council: *CPD activity examples.*
www.hpc-uk.org/registrants/cpd/activities

Department of Health. *A first class service: Quality in the new NHS.*
www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4006902

British Psychological Society CPD Policy
www.bps.org.uk/bps-learning-centre/cpd-resources/our-cpd-policy.cfm)

British Psychological Society Learning Centre
www.bps.org.uk/cpd

Division of Clinical Psychology Membership Services Unit – myCPD
www.bps.org.uk/myCPD

6. Appendix: CPD activities

A list of CPD activities.

1. Work-based Learning

- Learning by doing
- Case studies
- Reflective practice
- Clinical audit
- Coaching from others
- Discussions with colleagues
- Peer review
- Gaining, and learning from, experience
- Involvement in wider work of employer (for example, being a representative on a committee)
- Work shadowing
- Secondments
- Job rotation
- Journal club
- In-service training
- Supervising staff or students
- Visiting other departments and reporting back
- Expanding your role
- Analysing significant events
- Filling in self-assessment questionnaires
- Project work or project management
- Evidence of learning activities undertaken as part of your progression on the Knowledge and Skills Framework

2. Professional Activity

- Involvement in a professional body
- Membership of a specialist interest group
- Lecturing or teaching
- Mentoring
- Being an examiner
- Being a tutor
- Branch meetings
- Organising journal clubs or other specialist groups
- Maintaining or developing specialist skills (for example, musical skills)
- Being an expert witness
- Membership of other professional bodies or groups
- Giving presentations at conferences
- Organising accredited courses
- Supervising research
- Being a national assessor
- Being promoted

3. Formal/Educational

- Courses
- Further education
- Research
- Attending conferences
- Writing articles or papers
- Going to seminars
- Distance learning
- Courses accredited by professional body
- Planning or running a course

4. Self-directed Learning

- Reading journals/articles
- Reviewing books or articles
- Updating knowledge through the internet or TV
- Keeping a file of your progress

5. Other

- Public service
- Voluntary work
- Courses

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 254 9568 Fax 0116 247 0787 E-mail: mail@bps.org.uk Website: www.bps.org.uk

Incorporated by Royal Charter Registered Charity No 229642

REP85/12.2010

The British Psychological Society

Division of Clinical Psychology
Faculty for Learning Disabilities

Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Adults with Learning Disabilities

April 2012

Purpose and status of this document

This document has been prepared by a working group on behalf of the British Psychological Society's DCP Faculty for Learning Disabilities. Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the needs of individuals with learning disabilities and their carers, in whatever setting or context they come into contact with them. This revision of the original guidance issued in 2005 recognises that clinical psychologists are now likely to provide support to individuals with learning disabilities and their carers both within specialist health services and within mainstream health and social care. Hence the guidance sets out the knowledge and skills that clinical psychologists should acquire over the course of their training that will enable them to provide person-centered, effective, safe and dignified assessments and interventions for adults with learning disabilities, their carers and the systems supporting them.

The Faculty believes that it is the responsibility of each training course in conjunction with regional Faculty groups and supervisors to work jointly towards these aims and to use the present guidance to these effects. This guidance is in line with the current Accreditation Guidance for Clinical Psychology Programmes (BPS, 2010), which notes that:

- Programmes should refer to the minimum standards which are identified and revised from time to time by the Division of Clinical Psychology's Faculties for guidance in relation to the expected capabilities which a trainee should gain to fit them for work with specific populations and groups (p.13).
- National standards as set out by the DCP's Faculties and Special Interest Groups must also guide training patterns for each cohort of trainees (Section A3.5).
- The development of the (teaching programme's) syllabus should be informed by consultation with DCP Faculties and Special Interest Groups (Section B6).
- The national standards as set out by the Division of Clinical Psychology's Faculties will provide the reference information for the minimum supervised practice commensurate with competence in an area of work. Based on this reference information programmes must develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. Programmes must identify gaps in placement experiences provided, both individual and across the trainee cohort, and plan how they will structure the pattern of clinical training to overcome any deficiencies (Section C2).

Approval of this document is to be sought from the DCP Training Strategy Group (TSG) for publication and circulation by the DCP.

Prepared by a Working Party on behalf of the Faculty for People with Learning Disabilities. Published by The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR.
Comments & queries to k.scior@ucl.ac.uk, Doctorate in Clinical Psychology, University College London, Gower Street, London WC2E 6BT.

1. Introduction

It is estimated that around 2.5 % of the UK population have learning disabilities. While they are a diverse group with a range of needs and wishes, collectively they are one of the most vulnerable groups in society (DCP Faculty for Learning Disabilities, 2011). It is now widely recognised that they are at markedly increased risk of developing mental ill-health and a significant number present with behaviours that pose serious challenges to services (DCP Faculty for Learning Disability, 2011; Judith Trust, 2012). As a result they are more likely than people without cognitive impairments to require the support of clinical psychologists. Historically the needs of people with learning disabilities have largely been addressed by specialist learning disability services. Over the past few decades though there has been an increasing emphasis on 'mainstreaming' and a shift away from segregated services. These developments are closely in line with the White Paper *Valuing People* (DoH, 2001), its revision, *Valuing People Now* (DoH, 2009), and similar legislation in the devolved nations, which emphasise four key principles: rights, independence, choice and inclusion. Furthermore the *Improving Access to Psychological Therapy* (IAPT) programme has had a major impact on the delivery of psychological therapy in England and Wales. As a result of these developments, clinical psychologists are likely to meet people with learning disabilities across a wide range of specialities and within both specialist health services and mainstream health and social care. However, the government's aims to improve health outcomes and reduce inequalities in many cases remain a valued but distant ideal and there is now significant evidence that people with learning disabilities often experience problems accessing health care and equal treatment (DCP Faculty for Learning Disability, 2011). Thus there is a need to ensure that clinical psychologists in all specialities are well equipped to work with this client group, to know when a referral to specialist learning disability services is appropriate, and to know how to make, and help others to make, reasonable adjustments in line with the Disability Discrimination Act.

All support provided to individuals with learning disabilities should be person-centered, and should ensure that the service-user's perspective is paramount at all times and central to any interventions considered, including when working with carers, members of other disciplines and support agencies. The number of instances over recent years where adults with learning disabilities were the victims of severe abuse at the hands of those in whose care they had been placed, indicate that safeguarding continues to be a major concern. Similarly there has been increasing attention to hate crimes committed against individuals with learning disabilities. It is the Faculty's view that all psychologists need to have an understanding of this area, if they are to play a role in safeguarding individuals with learning disabilities, keeping them in their local communities and monitoring their welfare.

2. BPS Accreditation Guidance for Clinical Psychology Training Programmes

Historically many learning disability services experienced difficulties in recruiting clinical psychologists. While this is no longer the case, it is the Faculty's belief that training courses should encourage trainees to consider specializing in this area post-qualification. In order to positively promote recruitment to the learning disabilities field, training courses should ensure that trainees work with this client group and that misconceptions, which may result from lack of exposure rather than other factors, are challenged. As the inclusion of people with learning disabilities in mainstream health services continues to increase, the likelihood of clinical psychologists working outside specialist learning disability services working with individuals with learning disabilities as part of their work will also increase.

The BPS Accreditation guidance further sets out required learning outcomes. It is the Faculty's view that learning disability services typically offer a working context that is particularly suited to enable trainees to develop the following learning outcomes specified in the accreditation criteria. The Faculty recognises that other services can also contribute to developing some of these learning outcomes, but is of the view that those marked with * are most likely to be met or can only be met in the context of specialist learning disability services:

Communication and Teaching (Section 2.3.8 of Accreditation Guidance, BPS, 2010)

- **Adapting styles of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.*
- *Preparing and delivering teaching and training which takes into account the needs and goals of the participants.*

Service Delivery (Section 2.3.9)

- *Understanding of consultancy models and the contribution of consultancy to practice.*
- *Understanding of leadership theories and models, and their application to service development and delivery.* NB: It is the Faculty's view that work in the context of usually multidisciplinary learning disability settings lends itself very well to developing leadership skills.
- *Awareness of the legislative and national planning context of service delivery and clinical practice.*
- *Working effectively with formal service systems and procedures.*
- *Working with users and carers to facilitate their involvement in service planning and delivery.*

Clients (Section 3.6.1)

It is essential that trainees work with:

- *Problems ranging from those with mainly biological and/ or neuropsychological causation to those emanating mainly from psychosocial factors;*
- **Clients with significant levels of challenging behaviour;*
- **Clients across a range of levels of intellectual functioning over a range of ages, specifically to include experience with clients with developmental learning disabilities;*
- **Clients whose disability makes it difficult for them to communicate;*
- **Carers and families.*

Modes and type of work (Section 3.6.3)

- *Indirect, through staff and/or carers;*
- *Work within multi-disciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems;*
- *Work (i.e. practice, teach, give advice) in at least two evidence-based models of formal psychological therapy.* NB: It is the Faculty's view that work with adults with learning disabilities lends itself very well to learning to adapt evidence based models to clients' communicative and cognitive capabilities and show flexibility where required.
- *Work with complexity across a range of perspectives, demonstrating flexibility in application of whichever approach is most appropriate for the client or system.*

The UK health care context and the application of clinical psychology (Section 3.6.4)

Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken, including:

- *Legislation relevant to England and the devolved nations* (e.g. *Mental Capacity Act*, Disability Discrimination Act*, Mental Health Act, Health and Social Care Act, Adults with Incapacity Act* (Scotland), *Adult Support and Protection Act* (Scotland)).

- *Government policy statements* NB: It is the Faculty's view that work in the field of learning disabilities lends itself very well to learning about the immediate influence of policy on service delivery, not least the policy statements *Valuing People* (DoH, 2001) and *Valuing People Now* (DoH, 2009) and guidance such as the *Mansell Report* (DoH, 2007) and *No Secrets* (DoH, 2000)

3. Required competencies, experiences and service settings

The Faculty for Learning Disabilities has drawn up a list of competencies to assist training providers in ensuring that trainees have acquired the learning outcomes specified in the Accreditation guidance and have at least a basic capability to meet the needs of people with learning disabilities, wherever they may come into contact with them in their professional practice. The competencies listed below are based on the national policy document *Valuing People* (DoH, 2001) and its revision *Valuing People Now* (DoH, 2009), more specific guidance issued for Scotland (*The Same as You*, Scottish Government, 2000) and Wales (*Policy and Practice for Adults with a Learning Disability*, Welsh Assembly Government, 2007) and the *Accreditation Guidance for clinical psychology programmes* (BPS, 2010). It should be noted that some of these competencies are very specific to a learning disabilities context and thus are unlikely to be achieved in other areas (these have been marked *). Other competencies laid out below are of a more generic nature and may be met through work in other specialities.

3.1* Understanding of the history and current context of services for people with learning disabilities, including: historical constructions of 'learning disability', the marginalisation and stigmatisation of people with learning disabilities, institutionalisation, normalisation; the social model of disability; and the continued failure to safeguard adults with learning disabilities against abuse by those in whose care they have been placed.

3.2* Understanding of current policies, particularly *Valuing People* and *Valuing People Now* (and their Welsh and Scottish counterparts, where relevant), and means of service delivery, including inclusive education, person centred planning, personalised care and the Care Programme Approach as it applies to this client group.

3.3* Appreciation of the heterogeneity of people classified as having learning disabilities and an understanding of classification and epidemiological issues.

3.4 Ability to work with people who may be very different from trainees and at high risk of social exclusion, together with the ability to reflect on such work and feelings evoked.

3.5 Awareness of the impact of difference and diversity as they may affect both service uptake and engagement with psychological work. This includes an awareness of the risks of multiple sources of discrimination, not least for people with learning disabilities and their carers who are social disadvantaged, from black and minority ethnic or newly arrived communities.

3.6* Understanding of the biopsychosocial model as it applies to this speciality, including an understanding of possible causes of learning disabilities, the interaction of biology and behaviour (including behavioural phenotypes), autistic spectrum disorders, and possible physical and mental health problems and disabilities co-occurring alongside learning disabilities (e.g. sensory impairments, dementia).

3.7* Understanding of the impact of having learning disabilities across the lifespan, which may include diagnosis and intervention during the childhood years, transition during late teenage and early adult years, adulthood and older age. Trainees should also develop some understanding of the potential impact on family and paid carers of caring for a person with learning disabilities.

3.8* Understanding of the different contexts of which people with learning disabilities may be part: i.e. the family; special and mainstream education in schools and colleges; day and leisure

opportunities; vocational and employment opportunities; supported living schemes and residential care; and specialist care settings, such as inpatient generic and mental health settings, and forensic settings.

3.9* Ability to communicate, both face-to-face and in written/pictorial form, with people from across the whole spectrum of communication abilities, including individuals who are non-verbal, together with an awareness of communication issues and mediums to facilitate accessible communication.

3.10 Understanding of power differences between professionals and people who are marginalised or disempowered due to cognitive or communication deficits and how to address these in practice (e.g. minimising the risk of acquiescence, working psychologically in a less formal manner with individuals who have had aversive experience of formal settings).

3.11*Ability to adapt psychological assessments and interventions to the cognitive, communication, sensory, social and physical needs of people with learning disabilities and their carers.

3.12 Ability to complete a detailed functional analysis of behaviour and translate the results into appropriate guidelines which are sensitive to the needs of those implementing them, and recognise common barriers to successful implementation.

3.13*Ability to understand and respond to behaviour that challenges services in order to support people locally and reduce the likelihood of out-of-area placements. This will include an understanding of the role of positive behavioural support and ability to translate this into behaviour support plans.

3.14 Ability to develop multi-faceted formulations and interventions which take into account individual, systemic and organisational factors.

3.15 Ability to work with a range of service providers, including health, social services, education, the voluntary and private sectors.

3.16 Understanding of the potential vulnerability of adults from marginalised groups, knowledge of safeguarding policies and procedures, and ability to recognise signs of possible abuse.

3.17 Understanding of capacity and consent issues, ability to obtain informed consent and to contribute to multidisciplinary assessments relevant to capacity and, where a person is deemed to lack capacity, ability to sensitively inform 'Best Interests' procedures.

3.18 Ability to consult to diverse staff teams and adapt the communication of psychological theories and interventions to recipients' needs.

3.19 Ability to contribute to service development.

3.20 Ability to work with colleagues in multidisciplinary teams, liaise effectively with other services and professions and demonstrate leadership where called for.

3.21 Ability to design and deliver teaching and training that is clear, effective and closely matched to learners' needs.

4. Mechanisms for achieving these competencies

All clinical psychology training courses should ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 Academic Teaching

The Faculty believes that each academic programme must have a specialist learning disability component which covers knowledge and skills specific to work with people with learning disabilities, alongside teaching which integrates thinking about people with learning disabilities with other client groups in relation to specific clinical and contextual issues. Both specialist and integrated cross-speciality teaching which addresses the needs of people with learning disabilities should be developed and reviewed in regular consultation with the regional Faculty for Learning Disabilities group to reflect the views and needs of the speciality at both local and national level. Skills-based teaching should be delivered by clinicians specialising in the area of learning disabilities. Training programmes should aim to involve service users directly in teaching.

The Faculty recommends that each programme should cover the following areas as a minimum, either through specialist and/or integrated cross-speciality teaching:

- The history and current context of services for people with learning disabilities and current policies.
- Power differences between professionals and people with learning disabilities and how to address these in practice, and, where relevant, in research.
- The theory and practice of psychometric and adaptive functioning assessments.
- Current 'best practice' in establishing eligibility for learning disability services.
- The mental health needs of adults with learning disabilities.
- Adaptation of a range of therapeutic approaches, assessments and interventions to the needs of people with learning disabilities and their carers.
- Current perspectives on behaviours that challenge services, including positive behavior support.
- Functional analysis.
- Autism spectrum disorders, including causes, clinical presentations and appropriate interventions.
- A range of methods suitable for evaluating psychological work with people with learning disabilities.
- Capacity and consent issues and their implications for clinical practice.
- Supporting individuals with learning disabilities in relation to sexuality.
- Supporting parents who have learning disabilities.
- Dementia (including as it affects people with learning disabilities).
- Offending behavior in people with learning disabilities.
- The role of clinical psychology as part of providing good quality support to individuals with profound and multiple learning disabilities and their families (see Dept of Health, 2010)

4.2 Clinical Placements

The Faculty recognises that trainees may be able to acquire at least some of the competencies outlined above in a range of service contexts and with a range of client groups. However, it is the Faculty's belief that in order to be able to integrate their knowledge, skills and clinical experiences trainees should, wherever possible, gain substantial experience within the context of learning disability services. Wherever possible, this will be in the form of a dedicated learning disabilities placement. In considering any alternative arrangements to this model, clinical training courses and regional supervisors should jointly ensure that such arrangements will allow trainees to gain a thorough understanding of the context and heterogeneity as well as complexity of the client group. In any case training providers must ensure that trainees meet the minimum competences set out by the BPS accreditation guidance, above all they must have direct clinical experience of working with individuals with

learning disabilities; those with significant levels of challenging behaviour; and individuals whose disability makes it difficult for them to communicate (see section 2. above).

Trainees' supervised experience should include the following, wherever possible, and in whatever clinical setting that can provide such experiences:

Trainees should have substantive experience with people with learning disabilities with a mix of presenting problems in a variety of service settings and, across the lifespan, should be exposed to individuals from across the spectrum of learning disabilities, including individuals with severe and profound learning disabilities. The Faculty sees the following placement experiences as essential in ensuring that trainees will be able to meet the needs of individuals with learning disabilities upon qualification:

- work relating to someone whose behaviour is constructed as 'challenging', involving a comprehensive functional analysis;
- work relating to someone with an autistic spectrum disorder;
- work with a person with severe or profound learning disabilities;
- at least one detailed psychological assessment, which should include the use of formal measures (e.g. psychometric or functional assessment), and which should at least partly be completed directly with a person with learning disabilities;
- at least one direct assessment and intervention involving a person with learning disabilities;
- at least one assessment and intervention with family or paid carers; this could include indirect work with a staff team; and
- formal evaluation of the impact of a piece of psychological work, whether assessment (and feedback) or intervention.

The Faculty recognises that some high quality, yet very specialist placements, may not provide the range of experiences outlined above. It is intended that these recommendations should serve as a template to guide course staff, supervisors and trainees. The precise meaning of 'substantive experience' should be judged on an individual basis, bearing in mind that the entire training experience should enable trainees to demonstrate achievement of the learning outcomes outlined in Section 2 and to acquire the competencies outlined in Section 3. In some cases these may be acquired through work with quite a number of clients, in others through much more in-depth work with a few clients, supplemented by observation, discussion and reflection. The range and types of experiences outlined above are of course not mutually exclusive, but several may be addressed in in-depth work with the same individual or care system.

5. Review Process

These guidelines should be reviewed in 2017.

References

British Psychological Society (2010). *Accreditation through partnership handbook: Guidance for clinical psychology programmes.* Leicester: BPS.

DCP Faculty for People with Learning Disabilities (2011). *Commissioning Clinical Psychology services for adults with learning disabilities*. Leicester: BPS.

Department of Health (2000). *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London: Dept of Health.

Department of Health (2001). *Valuing People: A new strategy for learning disability for the 21st century*. London: Dept of Health.

Department of Health (2007). *Services for people with learning disability and challenging behaviour or mental health needs (Mansell Report)*. London: Dept of Health.

Department of Health (2009). *Valuing People Now: From Progress to Transformation.* London: Dept of Health.

Department of Health (2010). *Raising our sights: services for adults with profound intellectual and multiple disabilities.* London: Dept of Health.

Judith Trust (2012). *Advisory Paper to the Department of Health Mental ill-health in people with Learning Disabilities: a coordinated and considered care approach*. London: Judith Trust.

Scottish Government (2007). Adult Support and Protection (Scotland) Act.

Scottish Government (2000). Adults with Incapacity (Scotland) Act.

Scottish Government (2000). *The Same as You? A Review of Services for People with Learning Disabilities.* Edinburgh: Scottish Government.

Welsh Assembly Government (2007). *Statement on policy and practice for adults with a learning disability*. Cardiff: Welsh Government.

Appendix 1: Members of the Working Group

Sandra Baum, Consultant Clinical Psychologist, Community Health Services, Newham Directorate, East London Foundation Trust

Karen Dodd, Associate Director for Specialist Therapies - Learning Disabilities and Older Peoples Mental Health Services Surrey and Borders Partnership NHS Foundation Trust

Nan Holmes, Clinical Director, Doctorate in Clinical Psychology, University of Surrey

Kay Hughes, Consultant Clinical Psychologist, Plymouth Community Healthcare (CIC).

John Rose, Academic Director, ClinPsyD, University of Birmingham; Consultant Clinical Psychologist and Professional Lead, Dudley Community Services

Katrina Scior, Academic Director, DClinPsy, University College London (Chair of Working Party)

Comments on a draft were also received from the national committee of the DCP Faculty for Learning Disabilities

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Tel: 0116 252 9568 Fax: 0116 247 0787 E-mail: mail@bps.org.uk Website:
www.bps.org.uk

The British Psychological Society
Promoting excellence in psychology

Division of Clinical Psychology

DCP Policy on Supervision

May 2014

This document was written on behalf of the Division of Clinical Psychology Professional Standards Unity by:

Dr Catherine Dooley	Director, Division of Clinical Psychology Professional Standards Unit
Thomas Peyton–Lander	DCP Publications Assistant

Acknowledgements

The Division of Clinical Psychology Professional Standards Unit wishes to thank the following trusts:

- Camden and Islington NHS Foundation Trust, Camden Primary Care Trust and Islington Primary Care Trust for allowing us to use their 'Responsibilities of Psychology and Psychological Therapy Managers in Multi-professionally Managed Services' in Appendix E.
- South West London & St George's Mental Health Trust for allowing us to use their examples of 'Supervision Contracts' in Appendix A.

We would also like to thank the following people who contributed to the development and production of this document.

Tina Ball	Clinical Director, (Learning Disabilities), Sheffield Health & Social Care Trust
Dr Helen Beinart	Consultant Clinical Psychologist, Oxford Institute of Clinical Psychology Training, University of Oxford
Dr Laura Golding	Academic Director, DClinPsychol Programme, University of Liverpool
Jane Street	Consultant Clinical Psychologist, Associate Director for Psychology & Psychotherapies, Wandsworth and Clinical Lead, Wandsworth Psychological Therapies and Wellbeing Service (IAPT)

If you have problems reading this document and would like it in a different format, please contact us with your specific requirements.

Tel: 0116 252 9523; E-mail: P4P@bps.org.uk.

Contents

Page

DCP Equality and Diversity Statement

The British Psychological Society's *Code of Ethics and Conduct* (2009) is based on the four ethical principles of respect, competence, responsibility and integrity. This code is the basis for the Division of Clinical Psychology's work and is the foundation for the Division's diversity statement.

The Health and Care Professions Council (HCPC) as the regulatory body for the profession set out their statements in relation to equality and diversity in the *HCPC Equality and Diversity Scheme* (2007).

The Division of Clinical Psychology expects members to deliver services fairly in response to individual needs, and to behave with respect and decency to all. Members of the DCP do not discriminate based on a person's age; ability or disability; family circumstance; gender; political opinion; race, nationality, ethnic or national origin; religion or belief; sexual orientation; socio-economic background; or other distinctions. Such forms of discrimination represent a waste of human resources and a denial of opportunity.

The DCP recognises that discrimination, harassment and bullying does occur and expects members to challenge inappropriate behaviour and discriminatory practice either directly, or through working within cultures and systems to establish changes to practice.

Supervision is a critical element of clinical practice since it links scientific research to the realities of clinical work, and is the means by which theory becomes linked to practice (e.g. Fleming & Steen, 2012; Scaife 2001; Bernard & Goodyear, 1998).

Introduction

Supervision is one strand of clinical governance for professions within health services, alongside continuing professional development (CPD) and life-long learning to ensure safe and accountable practice and high quality clinical and professional services.

Supervision is identified within a range of documents in relation to the governance of professional practice, for instance the Care Quality Commission's *Essential Standards of Quality and Safety* (2010) and the Health and Care Professions Council's Standards of Practice 2c.2 (HCPC, 2011).

The Department of Health (1993) defines supervision as, 'A formal process for professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations. It is central to the process of learning and scope of the expansion of practice and should be seen as a means of encouraging self-assessment, analytical and reflective skill.'

Supervision within clinical psychology can be defined as 'the formal provision, by approved supervisors, of a relationship-based education and training that is case-focused and which manages, supports, develops and evaluates the work of junior colleagues'. (Milne, 2007)

This document updates and replaces previous guidance from the DCP on this area, namely *Policy Guidelines on Supervision in the Practice of Clinical Psychology* (2003) and *Continued Supervision* (2006). Reference should also be made to the BPS *Code of Ethics and Conduct* (2009), the BPS *Generic Professional Practice Guidelines* (2008), *DCP Continuing Professional Development Guidelines* (2010) and *DCP Guidelines on Activity for Clinical Psychologists* (2012). The BPS's *Register for Supervisors* (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision and these would be recommended as good practise for those offering supervision. (See Appendix D for RAPPS learning outcomes.)

This document confines itself primarily to the supervision needs of qualified clinical psychologists; supervision of trainee clinical psychologists is determined by additional guidance for clinical psychology training programmes: *Guidelines on Clinical Supervision* (BPS 2010). Supervising of assistant psychologists is addressed within the *Guidance on the Employment of Assistant Psychologists* (DCP, in preparation).

1. Aim of this document

The aim of this policy is to:

- Describe managerial, professional and clinical supervision.
- Set out standards for best practise in supervision for and by clinical psychologists.
- Outline responsibilities for the line/operational manager, supervisor and supervisee within this process. In particular, to demonstrate that the supervisee has a proactive role to bring concerns and issues to supervision and engage openly and honestly with the process.
- Reference how supervision, CPD and appraisal work together to provide a system for clinical governance and staff development.
- Provide guidance on the delivery, development and audit of supervision – such as contracts, recording, monitoring and audit.

1.1 Purpose and function of supervision

The primary purpose of supervision is to ensure the safety and quality of care and treatment for service users.

Supervision also supports professional development, developing and embedding new skills and ensuring adherence to good practice both in clinical and professional areas.

Where clinical psychologists work with more complex/transdiagnostic clients there is a particular role for supervision to support them to develop and refine (and re-refine) formulation and intervention plans.

Effective supervision also has a role in providing support for the individual and maintaining morale. This can be of particular value when psychologists are working in highly complex and sensitive areas – such as trauma or child sexual abuse – where the need to establish sufficient time to take issues to a safe and confidential place away from the normal work setting may need to be factored into the job plan.

At a time of ongoing change within services, the supervisory function has a particular role to allow the individual practitioner to reflect on the personal impact of their work and manage concerns in order to assist them in maintaining their level and standard of functioning.

Several models of supervision (see Beinart, 2012 for a review), identify supervision tasks and functions such as: education; support; quality assurance/monitoring; conceptualisation/formulation and consultation. These may occur in the broader service/team context and models such as Hawkins and Shohet (2012) and Holloway (1995) stress the importance of the broader context. Current theory and research also emphasises the centrality of the supervisory relationship to effective supervision, e.g. Beinart (2012) and Watkins (2013).

2. Standards and recommendations for good practise

These standards apply to all members of the DCP and provide a good practice benchmark for all clinical psychologists, although it is recognised that there may be different approaches within different organisations. Individuals in independent practice, either as sole practitioners or within an organised service, will require robust supervision arrangements that meet these standards and the underlying principles that underpin them.

1. All clinical psychologists, at all stages of their career and in all work contexts, will engage in regular planned supervision of their work.
2. All aspects of a clinical psychologist's work including clinical, consultancy, supervisory, research, educational, or managerial, will be subject to supervision.
3. The amount and frequency is dependent on context, experience and work demands:
   - 3.1 An absolute minimum will be one hour per month, one to one supervision with a psychologist, for all staff, however part time.
   - 3.2 It is recommended that a full time newly qualified clinical psychologist will have weekly clinical supervision for a minimum of one hour.
   - 3.3 It is recommended that a full time mid career clinical psychologist will have clinical supervision for a minimum of one hour per fortnight.
   - 3.4 It is recommended that a senior psychologist would have clinical supervision for a minimum of one hour per month.
4. It is recommended that a supervision contract (see Appendix A for examples), agreed and signed by supervisor and supervisee be established, and reviewed regularly, at least annually. The annual review will identify the amount of supervision required and incorporate supervision time in relation to the demands of the work and may be reflected in a work plan (DCP, 2012).
5. All clinical supervisors will be appropriately trained for the role.
6. All supervision will be documented and records kept (see Appendix B).
7. The individual has a responsibility to identify the need for and to seek access to supervision within their work situation.
8. Supervisors apply supervision models and best evidence to their supervisory practice and attend carefully to their supervisory relationships.
9. Supervisors demonstrate ethical practice and are respectful of diversity in all its forms.

3. Types of supervision

It is important conceptually to separate out:

- Line management supervision
- Professional supervision
- Clinical supervision.

In practise, in some services these three areas will each be dealt with within different supervisory arrangements, with an individual meeting with their team manager (a non-psychologist) on perhaps a monthly basis, meeting with their professional supervisor monthly and with the clinical supervisor on a weekly basis.

However, at times two or even all three may be combined within one supervisory relationship. In these situations it may be particularly important to ensure that all aspects are appropriately addressed. There are examples of matrices illustrating how and where the different elements may be met (Appendix C).

It should be noted that at times a particular issue will be and should be addressed in all three areas; one example would be a clinical issue concerning safeguarding of a vulnerable adult which may need to be discussed with the line manager (to support formal reporting), within professional supervision in terms of how the individual managed the situation and within clinical supervision to refine the clinical intervention.

3.1 Operational/line management supervision

Line management structures are determined by the employing organisation and line managers are responsible for developing systems for the managerial supervision of staff within their service. Line management supervision has a focus on appraisal and monitoring of performance, and is specifically concerned with operational issues and quality of service. This complies with clinical governance requirements, and addresses the need for accountability. Line management supervision ensures that staff perform the tasks they are paid to perform as part of the services that the organisation is commissioned to deliver. A key aim is to ensure that there is consistency between the individual's work and the objectives of the service.

3.2 Professional supervision

Professional supervision is a distinct function but may be combined with other roles. It has the overall focus on the individual as a professional within a professional role and its key function is to ensure that professional practice standards, ethics and codes of conduct are met.

Such supervision will address issues such as

- team working and relationships;
- progress against personal development plan (PDP) goals and organisational objectives from the appraisal;
- CPD needs and priorities;
- use of broader competencies, in particular leadership skills (DCP, 2010);

- professional and ethical issues and concerns; and
- longer term career development.

This offers a confidential (in so far as there are no concerns regarding fitness to practice and/or competence) reflective space for clinical psychologists to think and talk about their work, and their responses to the work.

Supervisors will need to possess solid understanding and expertise in key areas of professional competence for clinical psychologists, and have had appropriate preparation for their role of supervisor of qualified professional staff members. In most situations this would be provided by a psychologist in a more senior position; however, for senior psychologists peer supervision could be acceptable although this should be monitored within the appraisal system and access to a more senior psychologist should be available, even if external and in some circumstances necessitating providing funding to receive this from an external supervisor.

The frequency and duration of professional supervision will be of a standard that allows all aspects of work to be discussed, and enables the development of a beneficial supervisory relationship. This will be negotiated with, and agreed by all involved parties: supervisee, supervisor and line manager. A minimum standard is one professional supervisory session per month.

The focus, content, and process of supervision will be negotiated between supervisee and supervisor. The focus and content of supervisory discussions will shift and vary from individual to individual, over different work contexts, and over time.

Professional supervision may incorporate clinical supervision wholly or partly depending on the individual's need and/or the organisational context. Ideally the two would be kept separate or have clearly defined times as in practise one can easily be neglected in favour of the other.

3.3 Clinical supervision

Clinical supervision has the specific purpose to maintain, update and develop clinical skills in assessment, formulation and interventions. This may address clinical work from various orientations – complex cases, based on diagnoses/conditions, interventions or model specific.

Regular clinical supervision within the model of care that the clinician uses is a prerequisite for clinical practice. Such supervision also requires integration of clinical material with theoretical perspectives. There is a particular focus on the need to ensure that the work is evidence based and relates to most recent research and theoretical literature, as well as guidance from National Institute for Health and Care Excellence (NICE), the Scottish Intercollegiate Guidelines Network (SIGN) and other formal guidance.

The function is to ensure safe and effective practice within a respectful and trusting relationship. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

Clinical supervision will allow reflective space to review on-going clinical work where the individual practitioner can step back and critique this with a view to addressing biases or errors within work and learning new skills, having access to fresh ideas and new perspectives. It is invaluable in helping to deal with 'stuckness'. In particular it would allow the exploration of challenging attitudes and mind sets or particular mental frameworks.

This would also offer a 'safe space' to allow recognition of the personal impact of the work both generally and particularly at times with individual cases.

Traditionally the emphasis has been on the provision of reflective space but increasingly the formative and normative component is becoming stronger as demonstrated by clear guidance from NICE, SIGN and local protocols; in addition to the focus on payment by results (PBR) and the requirements for more immediate information on clinical activity. There is also the statutory aspect to the work, e.g. where a psychologist is working with a case where there is child sexual abuse or financial abuse of a vulnerable adult and safeguarding issues. The supervisor may need to give a clear message or other direction and this will be recorded formally.

In some areas of work, clinical supervision will be highly structured and model specific, such as within IAPT services. At times there may be supervision focusing on specific areas, such as development disorders/neuropsychology, trauma.

Where the clinician is working to develop clinical skills (and/or qualification) within a particular modality, such as cognitive, interpersonal, psycho-dynamic or systemic therapy, there may be externally determined standards required for accreditation for both the supervisor and supervisee. In this case there will be an expectation to prioritise time for such supervision (including possible travel), CPD opportunities or even to pay for external supervision.

Supervision is usually hierarchical with a more experienced supervisor providing supervision to a less experienced supervisee. However, clinical supervision is more competency based so it is possible that a more 'junior' staff member could provide clinical supervision to a more 'senior' member of staff. This may provide particular challenges to the supervisory relationship which need to be carefully negotiated and managed. With an increasingly wider range of clinical areas of work, and the need to be more self directed, individual practitioners are more likely to seek this collaborative, co-creative model. Regular supervision may be supplemented with ad hoc sessions (for instance where there is a recognised expert, e.g. in trauma, who colleagues utilise for specific cases). Increasingly, no one supervisor can meet all clinical supervision needs. Consultation is considered to be the term for ad hoc or one off use of supervision.

The status of any advice from the supervisor will vary given the level of qualification and autonomy of the practitioner – for newly qualified clinical psychologists or supervisees undertaking initial training in a new clinical areas, the supervisee might be advised to follow the advice of their supervisor. Once qualified, generally the psychologist is autonomous and decides whether to take advice; they would then be accountable as an individual for that judgement.

3.4. Alternative approaches to the provision of supervision

Supervision, especially clinical supervision, is normally considered to be provided one-to-one and face-to-face. However, there are many examples of alternative types of provision. Clinical supervision could be group based, with an identified lead, or peer based, with all members sharing expertise. It can be conducted by telephone (such as is common within Mindfulness-based CBT); Skype or other instant messaging solutions as well as email. Some models (e.g. systemic) use reflective teams or live supervision, where the supervisor is in the room with the clinician and client. Good practice would indicate the use of recorded or observed material within supervision at times.

These approaches all have benefits, even if primarily pragmatic, but there would also be disadvantages and a situation where a psychologist did not receive face-to-face and one-to-one supervision with reasonable frequency would not be considered acceptable practise.

3.5. Informed consent from clients in relation to supervision

Clinical psychologists will inform clients and supervisees of their own supervisory arrangements. Clients undertaking a course of formal psychological therapy will be informed of the fact that all therapists use clinical supervision as part of their work. Clinical psychologists will attempt to gain a general and informed consent from clients and supervisees for those occasions where potentially identifiable case or supervisory material needs to be part of supervisory discussions.

4. Complex issues that might arise in supervision

4.1 Aspects of the supervisory relationship

There can be a number of issues that arise in supervision that require careful management. The prime concern for all practitioners should be patient safety and well-being; this will also include concern about the wider governance of the service and the provision of safe and effective care, as well as professional ethics.

Some examples are:

- concerns about confidentiality, breaches of information governance;
- reporting of safeguarding issues;
- whistle blowing;
- personal issues – for instance, managing carer responsibilities;
- concerns about own fitness to practise;
- concerns about others fitness to practise;
- addressing capability issues within one's position, for instance being asked to take on work that is outside current skill range;
- ethical dilemmas within the local team/service; and
- managing boundary violations or dual relationships.

These issues could arise within different areas of supervision and may require different

courses of action. Most organisations have policies and procedures in relation to these areas, and the human resources department may be able to assist; in some areas the Health and Care Professions Council (HCPC) might need to be involved.

It needs to be stressed that supervision should not be viewed as 'personal therapy' for the supervisee; it could be easy for boundaries to be affected. In such situations it may be valuable for the supervisor to take this to their own professional supervision to ensure that they provide the right balance, for instance where a staff member brings an issue such as their own substance misuse to supervision.

Supervisory space needs to be a safe space for the individual but there can be times when organisational changes threaten this. Increasingly, as work roles change, there may be boundary issues that affect the supervisory relationship, such as for instance in a reorganisation where two psychologists were originally peers but now one is in a more senior position than the other. A supportive and contained relationship between supervisor and supervisee are cited as factors promoting satisfaction with supervision. In order to achieve these goals a supervisor and supervisee should have an explicit agreement about the circumstances under which issues discussed in supervision will be discussed with a third party. This should be reflected in the supervision contract, e.g. under 'boundaries' and should include reference to third party discussion where:

- concerns about the supervisee's work with service users are not being resolved through supervision;
- concerns about the supervisee's well-being are not being resolved through supervision;
- there appears to be a breach of the HCPC's *Standards of Proficiency*, BPS *Code of Conduct, Ethical Principles and Guidelines*, the DCP's *Professional Practice Guidelines* or the DCP's *Core Purpose and Philosophy of the Profession* on the part of the supervisee or supervisor; and
- behaviour on the part of the supervisor or supervisee where disciplinary proceedings might apply.

4.2 Sociocultural aspects to consider in supervision

The relationship between the supervisor and supervisee must be built on mutual trust and respect to ensure safe and effective practice. As there may be a high level of personal disclosure, strong emotions and also at times a high amount of challenge from the supervisor it is crucial that a good relationship is engendered and supported.

It is therefore important to recognise that people who have grown up in sexist, homophobic, racist or other discriminatory cultures may have problems building a trustful relationship between themselves and a supervisor or supervisee who comes from a very different cultural background. In such instances, if this cannot be resolved by discussion and internal mediation, the reallocation of the supervisor or supervisee without prejudice may be the only possible solution to ensure a good outcome.

4.3 Diversity impact assessment in relation to supervision

Category	Impact	Solution
1. Age	Differences in experience, values, knowledge and understanding.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
2. Disability (including long-term physical health problems)	Access, travel, time commitment, impact of sensory impairment.	Deal with practical issues, including reducing travel and ensuring accessible facilities. Possible reallocation of supervisor or supervisee without prejudice. Ensure aids and adaptations are provided.
3. Religion/ 4. Culture	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
5. Pregnancy and maternity	Possible gaps in continuity, maternity leave, childcare.	Need to ensure standards are met, especially around continuity of supervision.
6. Marriage and civil partnerships	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.
7. Sexual orientation and 8 Gender re-assignment	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor supervisee without prejudice.
9. Gender	Differences in experience, values, knowledge and understanding. Conflicting belief systems.	Can be worked through in an open, accepting and trustful setting. Possible reallocation of supervisor or supervisee without prejudice.

5. Quality, aspects of effective supervision

5.1 Expertise in the provision of effective supervision

The Society's Register for Supervisors (RAPPS) contains standards for knowledge, skills, experience and understanding for the provision of effective supervision at an introductory level and is recommended as good practise for those offering supervision. These are attached in Appendix F.

5.2 Training and CPD for supervisors

The supervisor will ensure that they have attended core supervision skills training and undertake further regular training relating to supervision over the course of their career. There are introductory and advanced training available from most of the training courses for placement supervisors. The BPS and many training courses provide training that is BPS approved and confers eligibility for the Register for Applied Psychology Practitioner Supervisors.

5.3 Problems in accessing supervision

There may be some settings where it is difficult to access suitable supervision to meet these standards, where, for instance, a psychologist is the only psychologist working in an organisation, for example, the sole clinical psychologist within an district general hospital or in an independent or third sector provider. In these situations, the individual and their manager will need to ensure they meet the standards of the HCPC and BPS and use this document to ensure the supervision needs are met. It would be advised to liaise with local DCP branch chairs for professional advice.

5.4 Monitoring and audit

All services employing clinical psychologists will ensure that effective supervision is provided and received. This can be monitored in a variety of ways, including formal audit and via annual appraisals.

The outcomes of supervision will be systematically reviewed and evaluated on a regular basis (at least annually). A minimum audit would be to ensure that psychologists all have this at the minimum frequency and more detailed analysis of qualitative aspects, such as the content and purpose. An ideal would be annual monitoring of the quality of supervision via a survey of supervisees associated with annual appraisal.

6. Conclusion

This document updates the guidance from the DCP for members and builds on that provided by earlier documents.

It sets clear standards in terms of supervision in relation to grades, quality aspects of supervision and for the supervisors in providing supervision.

It has become clear during the process of writing this document that supervision within clinical psychology is very much an area in development in terms of:

- the emergent literature on theoretical aspects of supervision;
- the work on a competency framework for supervisors; and
- the currents plans to take forward the RAPPS system to accredit supervisors.

It is hoped that the guidance within this document will be relevant over a reasonable timescale; it had been written, where appropriate, quite broadly to ensure that the increasingly diverse work contexts within the delivery of psychological services are addressed within it.

References

Beinart, H. & Clohessy, S. (2009). Clinical supervision. In H. Beinart, Kennedy, P. & S. Llewelyn (Eds.), *Clinical psychology in practice*. Oxford: Wiley-Blackwell.

Beinart, H. (2012). Models of supervision and the supervisory relationship. Fleming, I. & Steen, L. (2012). *Supervision and clinical psychology: Theory, practice and perspectives* (2nd edn). Hove: Routledge.

Bernard, J.M. & Goodyear, R.K. (1998). *Fundamentals of clinical supervision* (2nd edn). London: Allyn & Bacon.

British Psychological Society (2008). *Generic professional practice guidelines*. Leicester: Author.

British Psychological Society (2009). *Code of ethics and conduct*. Leicester: Author.

Care Quality Commission (2010). *Essential standards of quality and safety*. London: Author.

Department of Health (1993). *A vision for the future. Report of the Chief Nursing Officer*. London: DoH.

Division of Clinical Psychology (2010). *Continuing professional development guidelines*. Leicester: British Psychological Society.

Division of Clinical Psychology (2010). *Clinical psychology leadership development framework*. Leicester: British Psychological Society.

Division of Clinical Psychology (2012). *Guidelines on activity for clinical psychologists*. Leicester: British Psychological Society.

Fleming, I. & Steen, L. (2012). *Supervision and clinical psychology: Theory, practice and perspectives* (2nd edn). Hove: Routledge.

Hawkins, P. & Shohet, R. (2012). *Supervision in the helping professions* (4th edn). Milton Keynes: Open University Press.

Health and Care Professions Council (2007). *Equality and diversity scheme*. London: Author.

Health and Care Professions Council (2011). *Continued professional development and your registration*. London: Author.

Health and Care Professions Council (2012). *Standards of proficiency – practitioner psychologists*. London: Author.

Holloway, E. (1995). *Clinical supervision: A systems approach*. Thousand Oaks, CA: Sage Publications Inc.

Milne, D. (2007). An empirical definition of clinical supervision. British *Journal of Clinical Psychology, 46*, pp.437–447.

Partnership and Accreditation Team (2010). *Additional guidance for clinical psychology training programmes: Guidelines on clinical supervision*. Leicester: British Psychological Society.

Scaife, J. (2001). *Supervision in the mental health professions*. New York: Brunner-Routledge.

Watkins, C.E. Jnr. (2013). The contemporary practice of effective psychoanalytic supervision. *American Psychological Association, 30*(2), pp.300–328.

Appendix A. Two examples of supervision contracts

SAMPLE CONTRACT FOR INDIVIDUAL AND GROUP CLINICAL SUPERVISION OF PSYCHOLOGICAL THERAPY

For use by all qualified practitioners within …….

Name of Supervisee (s): .....

Name of Supervisor: .....

Work Base: .....

Place of Supervision: .....

The supervision contract is a commitment by the supervisor and the supervisee to enable the supervisee, as a qualified practitioner of psychological therapy, to discuss in confidence issues relating to their clinical work with clients/patients, to ensure safe practice and to enable the development and maintenance of clinical therapeutic skills.

1) Supervision will take place on a …… weekly basis for ……. hours.
2) Supervision will usually be provided individually unless otherwise agreed and reviewed at least annually.
3) The supervisor has the responsibility of ensuring that a private venue (as free from interruption as possible) is available and booked for each session.
4) Sessions cancelled unavoidably due to annual leave, sick leave, etc, should be re-booked as soon as convenient to both parties.
5) Notes will be taken by the supervisor and a copy given to the supervisee.
6) Subjects discussed will be treated as confidential as set out by the Trust's guidelines on supervision.
7) The supervisee has the responsibility to highlight in supervision concerns, pressures and information they feel the supervisor should be aware of.
8) The supervisor has responsibility to use supervision to provide structure, support and exploration to maintain, enhance and/or develop the supervisee's clinical skills.
9) ……. is the qualified clinician who will act as third party, in a consultative role, if difficulties and conflicts arise between supervisor and supervisee.
10) When requested the supervisor will provide feedback for the supervisee's appraisal.

Date agreed: ..... Review date: .....

Signed:

Supervisor: ..... Supervisee: .....

PROFESSIONAL SUPERVISION CONTRACT

Supervisor: ..... Supervisee: .....

Date contract agreed: ..... Contract to be reviewed: .....
(Minimum annually)

Frequency of supervision: Monthly Duration of each session: 1–1.5 hours

Focus:

The professional supervisor ensures that the individual clinician is working within appropriate professional boundaries, and is adhering to appropriate professional standards, in line with the objectives of the service and the Trust. They also contribute to appraisals, identification of training needs and reviewing of objectives in the personal development plan.

The primary focus of professional supervision will therefore be on the development and maintenance of professional and clinical skills appropriate to the role of the supervisee.

Clinical caseload/workload will be reviewed routinely to monitor the types of clinical work undertaken, the caseload mix, waiting times and the development of clinical expertise.

Appraisal objectives will be routinely reviewed.

CPD activities will be reviewed and objectives discussed/recorded.

The supervisee will take responsibility for highlighting areas of need for further support in relation to specific aspects of clinical work, professional roles or managerial tasks.

Issues discussed and agreed outcomes will be recorded and agreed by both parties for each supervision session. The notes will be emailed to the supervisee who will then be able to comment or amend if necessary

Boundaries:

Regular supervision will be scheduled by agreement at the frequency specified with a commitment to good time keeping and avoidance of interruption.

Where issues of personal well-being are of concern to either party and appear to fall outside of the supervisory relationship, a third party (within the department) may be consulted with the permission of the supervisee/supervisor. We have identified XX.

The content of supervision and associated written records are confidential unless there are concerns raised about competence or risk.

Material from supervision/related records, specific to either party, is only to be discussed outside of supervision with the agreement of the supervisee and/or supervisor except where it is necessary to consult with a third party in the event of concerns regarding clinical or professional misconduct on the part of either the supervisor or supervisee.

Signed:

Supervisor: ..... Supervisee: .....

Date: .....

Appendix B: Recording of supervision sessions

Good practise would indicate that the recording of supervision sessions should include:

a. Copies of all supervisory contracts and updates to the contract.
b. The date and duration of each session.
c. A supervision logbook should be kept, and include at least minimal notes on the content of supervision, decisions reached, agreed actions.
d. A written record should be made of all regular reviews, including outcomes, of supervision. This would normally be the responsibility of the supervisor to ensure that a record is kept.
e. In some situations (e.g. risk issues) it would be good practice to also record a discussion and/or agreement within the relevant case file or as part of the clinical record; this is the responsibility of the supervisee. It would be good practise to record within the clinical case record, in particular any clinical decisions. The supervisee will record in the clinical record any risk issues and how they are addressed.

Appendix C: Psychology and Psychological Therapies: Responsibilities of psychology and psychological therapy managers in multiprofessional managed services

1. This document sets out the responsibilities of psychology professional management in multi-professionally managed services and teams. The majority of NHS services are multi-professional and managed through general service managers and/or clinical directors. Professional management supplements service management, with responsibility for managing and advising on profession specific areas where general managers may not have expertise. This paper clarifies the respective responsibilities of service and professional managers where these may be unclear.

2. Service management involves all aspects of managing the service/team. It includes:
   - Strategic direction for the service
   - Operational policies
   - Clinical governance of the service
   - Workload allocation
   - Supervision of staff in relation to their work in the service.

3. Professional management involves ensuring the professional standards and continuously improving the professional quality of work of professional staff. It includes:
   - Appointment of professionally competent and skilled staff
   - Profession specific elements of clinical governance – professional standards assurance and quality improvement
   - Profession specific clinical supervision
   - Continuing professional development.

4. Responsibility for hiring, appraisal and disciplinary matters can rest with either service or professional management. Line management is the term often used for this 'hiring and firing' responsibility. Sometimes there is a degree of vagueness as to which of service or professional manager has the line responsibility or it may be stated that this responsibility is shared.

5. As there can be different understandings as to what is the responsibility of service management and what of professional management, it can be useful to set out and agree the specific responsibilities of each. The Appendix is a suggested matrix of the respective responsibilities of service/team managers and psychology/psychological therapy professional managers in relation to psychologists and psychological therapists working in a multi-professional team. In this example, the psychology professional manager takes the line management responsibilities.

6. Job descriptions should include that the post holder is responsible to both service manager and professional manager. The precise form of wording will vary depending on the balance of responsibilities. In the example in the Appendix where the psychology/psychological therapy manager undertakes line management responsibilities for a psychologist who is working in two different teams, the job description should set out the relationship with regard to line management arrangements for both teams.

	Service/team manager	Psychology/psychological therapy manager
Recruitment	Contributes to writing and agreeing job description, recruitment procedures and selection of candidates.	Leads on recruitment, ensuring team/service manager(s) agree job description and procedures for selection of candidates.
Induction	Lead for induction is by agreement between service/team manager(s) and psychology manager, with the other contributing. Where psychologist is to work full-time in a team, the service/team manager will usually be responsible for induction; where the psychologist will work in more than one team, the psychology manager will usually be responsible.	
Work allocation	Responsible for allocation of work within the team/service.	Advises service/team manager(s) on parameters of appropriate kind of work/roles for psychologist in the team.
Standards, quality monitoring and clinical governance	Responsible for monitoring and ensuring work of the psychologist is within the policies and standards of the team/service.	Responsible for standards, quality monitoring and clinical governance of specialist psychology work in the team, within overall clinical governance arrangements of the team.
Appraisal/ IPR	Where a psychologist is full-time in a team/service, the service/team manager and psychology manager jointly carry out the annual IPR/ appraisal. Where the psychologist works in more than one team/service, the psychology manager leads on the annual appraisal/IPR and ensures the relevant team/service managers contribute and agree IPR objectives.	
Training and CPD	Contributes to setting CPD goals as part of the IPR process and scheduling and facilitation of CPD.	Responsible for agreeing annual CPD plan and facilitating psychologist in undertaking agreed CPD, with involvement of team/service manager(s) in setting CPD goals and scheduling of CPD.
Annual leave/ absence monitoring	Lead responsibility for agreeing annual leave and ensuring absence reporting and monitoring is by agreement between service/team manager and psychology manager, with the other contributing. Where psychologist works full-time in a team, the service/team manager will usually be responsible for leave arrangements; where the psychologist works in more than one team, the psychology manager will usually be responsible.	
Disciplinary	Ensures matters that might require formal disciplinary procedures are brought to the attention of the psychology manager. Liaises with psychology manager in taking forward disciplinary procedures where these relate to the performance of the psychologist in the team/service.	Responsible for any needed disciplinary procedures, with involvement of service/team manager(s) as needed.

While in principle, these respective responsibilities can be detailed in the job description of the post, in most cases a summary of line management and reporting arrangements for both teams should be sufficient.

Appendix D: RAPPS learning outcomes

Understanding and application

1. Have knowledge of the context (including professional, ethical and legal) within which supervision is provided and an understanding of the inherent responsibility.
2. Have an understanding of the importance of modelling the professional role, e.g. managing boundaries, including protecting time), confidentiality, accountability.
3. Have knowledge of developmental models of learning which may have an impact on supervision.
4. Have knowledge of a number of supervision frameworks that could be used for understanding and managing the supervisory process.
5. Have an understanding of the importance of a safe environment in facilitating learning and of the factors that affect the development of a supervisory relationship.
6. Have skills and experience in developing and maintaining a supervisory alliance.
7. Have knowledge of the structure of supervised professional experience including assessment procedures at different levels of qualification up to Chartered status level, and the changing expectations regarding the supervisor's role.
8. Have skills and experience in contracting and negotiating with supervisees.
9. Have an understanding of the transferability of professional skills into supervision and the similarities and differences.
10. Have an understanding of the process of assessment and failure, and skills and experience in evaluating supervisees.
11. Have skills and experience in the art of constructive criticism, on-going positive feedback and critical feedback where necessary.
12. Have knowledge of the various methods to gain information and give feedback (e.g. self report, audio and video tapes, colleague and client reports).
13. Have skills and experience of using a range of supervisory approaches and methods.
14. Have knowledge of ethical issues in supervision and an understanding of how this may affect the supervisory process, including power differentials.
15. Have an understanding of the issues around difference and diversity in supervision.
16. Have an awareness of the on-going development of supervisory skills and the need for further reflection/supervision training.
17. Have knowledge of techniques and processes to evaluate supervision, including eliciting feedback.

Printed and published by the British Psychological Society.

The British Psychological Society
St Andrews House, 48 Princess Road East, Leicester LE1 7DR, UK
Telephone 0116 254 9568 Facsimile 0116 247 0787
E-mail mail@bps.org.uk Website www.bps.org.uk

Incorporated by Royal Charter Registered Charity No 229642

INF224/05.2014

the british psychological society
promoting excellence in psychology

GOOD PRACTICE GUIDELINES

Training and consolidation of clinical practice in relation to adults with intellectual disabilities

For UK Clinical Psychology Training Providers

28 February 2021

Division of Clinical Psychology
Faculty for People with Intellectual Disabilities

WORKING GROUP MEMBERS

Barbara Barter Consultant Clinical Psychologist, South London and Maudsley NHS and Clinical Tutor IoPPN DClinPsych Programme, King's College London

Moira Phillips Consultant Clinical Psychologist, NHS Greater Glasgow and Clyde; BPS DCP FPID Scottish Representative

Alison Spencer Clinical Psychologist, Hertfordshire Partnership Foundation NHS Trust and Clinical Tutor, DClinPsy Programme, University of Essex

Julie Steel Consultant Clinical Psychologist, Kent and Medway NHS and Social Care Partnership Trust

Kate Theodore Clinical Psychologist, Central London Community Healthcare NHS Trust and Senior Lecturer/Clinical Tutor, Royal Holloway University of London DClinPsych

ACKNOWLEDGEMENTS

Jason Crabtree Consultant Clinical Psychologist for People with Learning Disabilities, East London NHS Foundation Trust

Ro Rossiter Consultant Clinical Psychologist/Honorary Researcher, Tizard Centre, University of Kent; BPS DCP Faculty for Children, Young People and their Families Learning Disability Network

Hayley Thomas Consultant Clinical Psychologist; BPS DCP FPID Welsh Representative

WITH THANKS TO PROGRAMMES WHO CONTRIBUTED

Lancaster University

University of Bath

University of Glasgow

Royal Holloway University of London

Salomons Centre for Applied Psychology, Canterbury Christ Church University

University of Essex

CONTENTS

PURPOSE AND STATUS OF THIS DOCUMENT

This document has been prepared by a working group on behalf of the British Psychological Society's Division of Clinical Psychology (DCP) Faculty for People with Intellectual Disabilities (FpID). Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the psychological needs of individuals with intellectual disabilities and their support networks in whatever context or setting they work in. This guidance was originally published in 2005 and was revised in 2012 (BPS, 2012) to reflect changes in health and social care.

This revision is based on the original guidance and is updated with key national policy changes. Hence, the guidance sets out the knowledge and experience that clinical psychologists should acquire over their training that will enable them to provide person centred, effective and safe clinical interventions for adults with intellectual disabilities and their supporting networks.

The Faculty believes that it is the responsibility of each training course in conjunction with regional faculty groups, local clinical psychologists and supervisors to work jointly toward achieving these aims. This guidance is in line with current *Accreditation Guidance for Clinical Psychology Programmes* (BPS, 2019) which highlights the following:

- In meeting the requirements of a professional training in clinical psychology, programmes should be sufficiently flexible in content and structure to adapt readily to current and future needs and to the emergence of new knowledge in clinical psychology and related fields. They should also play a major part in the identification of such needs and the development of innovative practices. Programmes should refer to the standards and guidelines, which are identified and revised from time to time by the faculties of the Division of Clinical Psychology, for guidance in relation to the knowledge and skills required to work with specific populations and groups (p.6).
- National standards as set out by the faculties of the Division of Clinical Psychology should guide training patterns for each cohort of trainees and programmes should consult with these and other local stakeholders to ensure that across the trainee cohort there is optimum, effective and efficient use of all available placements (Section 2.1.4.6).
- The content of curricula should reflect relevant and up to date psychological knowledge and skills, ensuring that contemporary psychological practice and research is promoted. Programmes should be able to demonstrate how the syllabus has been informed by general and specific guidance such as DCP policy (including faculty good practice guidelines) (Section 2.2.5.1).
- The national standards as set out by the faculties of the Division of Clinical Psychology should provide reference information for supervised practice commensurate with competence in a given area of work. Based on this reference information programmes will develop, in consultation with local psychologists, their own guidelines on required experience, recommending an appropriate amount of clinical work. The degree to which programmes privilege particular faculty guidance is one way in which they might develop specific strengths and the emergence of a unique identity (Section 2.4.1.6).
- An adequate balance of time must be allocated across services and client groups, and optimum use made of available placements, so that the required range of experience across the lifespan may be gained (Section 2.4.1.6.).

1. INTRODUCTION

In August 2018, NHS England announced that 'learning disabilities (LD)[1] and autism' will be one of four clinical priorities in its 10 year plan. A recent NHS commissioned report by the Institute for Health Equity concludes that there is a need for more action to tackle the social determinants of health (Rickard & Donkin, 2018). Professor Sir Michael Marmot notes that people with LD are more likely than the general population to experience 'some of the worst of what society has to offer', including low incomes, unemployment, poor housing, social isolation and loneliness, bullying and abuse. Health inequalities are also highlighted for people with Learning Disabilities in Scotland and Wales (NHS Scotland, 2017).

Since the last edition of this guidance in 2012, there has been a great deal of guidance and policy published under the Transforming Care Agenda (Department of Health, 2012) in response to the abuse scandal that occurred at Winterbourne View Hospital. Tragically people with LD continue to be the subject of national scandals in relation to their care and treatment, as was discovered at Whorlton Hall (BBC, 2019) and Muckamore Abbey (Department of Health Northern Ireland, 2020).

The findings in relation to Connor Sparrowhawk (Verita, 2015) and other deaths, have highlighted that when people with LD are not considered carefully, they tend to be at risk of neglect or maltreatment from the services that are supposed to keep them safe and well. The confidential inquiry into the premature deaths of people with LD (CIPOLD, 2013) highlighted that the quality and effectiveness of health and social care for people with LD has been shown to be deficient in a number of ways and made recommendations to reduce preventable deaths and reduce health inequality. This has been especially pertinent given the coronavirus pandemic and the disproportionate impact that this has had on people with learning disabilities (NHSE, 2020; BBC 2020, Mencap 2020).

People with ID continue to experience a higher rate of mental health conditions, recently estimated at 25% of the population, compared to 17.2% of people with average intellectual ability, and 13.4% of people with above average intellectual ability (McManus et al., 2016). There is a clear commitment in Scotland to increase access to psychological therapies, detailed in Scotland's LD strategy (2013), and supported by the NHS Education Scotland (NES) Educational Framework (2017) which aims to upskill the existing multi-professional workforce with clear roles for Clinical Psychologists working with adults with learning disabilities. These documents emphasise the need for a continued focus for robust training on psychological interventions for individuals with intellectual disabilities experiencing mental health and or behavioural difficulties. A similar commitment is outlined in Wales (Mental Health Wales Measure, 2010; Public Health Wales, 2017).

A consensus is arising within the field that there are some features of psychological work in LD services that are now essential practice. Chief among these is positive behaviour support (PBS), which was the subject of a special edition of *Clinical Psychology Forum* in February 2017 (BPS, 2017a) and the more recent position statement (BPS, 2018). The Faculty believes that all trainee clinical psychologists should develop competency in PBS so that they may take a leading role in ensuring its implementation across the board (Skelly et al., 2019). This view was given a clear policy base in *A Positive and Proactive Workforce* (Skills for Health and Skills for Care, 2014). It is incumbent on the NHS to reduce restrictive practices; for example, the 'Stopping over medication of people with LD' agenda (STOMP, NHSE, 2016). Where possible individuals should have access to PBS in order

[1] For the purposes of this document the terms intellectual disability and learning disability are used interchangeably.

to achieve this (Department of Health, 2014). The Scottish Government report *Coming Home: A report on out-of-area placement and delayed discharge for people with learning disabilities and complex needs* (2018), also promotes PBS as best practice. This Faculty takes the position that this requires competency in PBS and that clinical psychologists are potentially well placed, if not uniquely placed in terms of knowledge and skills to deliver PBS, and so reduce these restrictive practices (PBS Academy, 2015).

People with ID are at higher risk of adverse childhood experiences (ACEs) and other forms of adverse experience in adulthood (Spencer et al., 2005) with concomitant attachment difficulties (BPS, 2017b). According to a large scale prospective study in the UK by Spencer et al. (2005), children with LD are 5.3 times more likely to be neglected than other children, 2.9 times more likely to be emotionally abused, 3.4 times more likely to be physically abused, and 6.3 times more likely to be sexually abused. It is also likely that abuse and neglect is often unreported (Sullivan & Knutson, 2000). Adult women with LD may be at more than double the risk of sexual assault in the previous 12 months (Martin et al., 2006). Women with LD who are married or have a common law partner are at heightened risk of unwanted sexual activity and violence (Brownbridge, 2006). NHS Education Scotland and the Scottish Government have committed to developing a trauma informed workforce at a national level across organisations. This Faculty supports the recent emphasis on trauma-informed care within psychological care services (Skelly et al., 2019) and has recently developed a clinical practice guideline for clinical psychologists within LD services to consider the features of attachment theory that can be applied within the provision of care (BPS, 2017b).

There is a need to ensure that clinical psychologists in all specialties and settings are equipped to work with individuals with learning disabilities. They should know when to make a referral to a specialist learning disability service and how to make and help others to make reasonable adjustments in line with the Disability Discrimination Act (1995) and the Equality Act (2010). Overall, these guidelines aim to outline the minimum training requirements for doctoral programmes so that clinical psychologists in training acquire the skills, experience and competencies to achieve this.

2. BPS ACCREDITATION GUIDANCE FOR CLINICAL PSYCHOLOGY TRAINING PROGRAMMES

Accredited doctoral programmes in clinical psychology require approval by the Health and Care Professions Council (HCPC). The HCPC's role is to assure threshold levels of quality, by ensuring that graduates of approved programmes meet the Standards of Proficiency. The BPS accreditation guidance (BPS, 2019) sets out required learning outcomes in line with the HCPC and is designed to work beyond those quality thresholds by promoting quality enhancement.

It is this Faculty's view that learning disability services typically offer a working context that is suited to enable trainees to develop the following learning outcomes specified in the accreditation criteria. These are outlined in Appendix 1. It is the Faculty's view that the learning outcomes marked * are most likely to be met or can only be met in the context of specialist ID services.

3. REQUIRED COMPETENCIES, EXPERIENCES AND SERVICE SETTINGS

The Faculty has updated a list of competencies to assist training providers to ensure that trainees have acquired the learning outcomes specified in the accreditation guidance. Upon qualifying, trainees must have at least a basic competence in meeting the needs of people with LD in either mainstream or specialist services.

	DOMAIN	SUPPORTING POLICIES AND GUIDANCE
3.1*	Understanding of the history and current context of services for people with learning disabilities including historical constructions of 'learning disability', the marginalisation and stigmatisation of people with LD, institutionalisation, normalisation; the social model of disability and the continued failure to safeguard adults with LD against abuse by those in whose care they have been placed.	(DoH 2009, 2012)
3.2*	Ability to screen for and diagnose learning disability and understand the implications of such. Understanding of the heterogeneity of people classified as having LD and understanding of classification and epidemiological issues.	(BPS, 2015a)
3.3	Understanding of current policies and means of service delivery including access to inclusive education, person centred planning, and personalised care as it applies to this client group.	DoH, (2009, 2012) Scottish Government (2013) Learning Disability Professional Senate (2015, revised 2019)
3.4	Ability to work with people at high risk of social exclusion. Awareness of the impact of difference and diversity as they may affect both service uptake and engagement with services including psychological work. This includes an awareness of the risks of multiple and interacting sources of discrimination (e.g. race, culture, ethnicity, religion, sexuality).	
3.5*	Understanding of the biopsychosocial model as it applies to this speciality, including an understanding of possible causes of LD, the interaction of biology and behaviour (including behavioural phenotypes), autistic spectrum disorders, the possible physical and mental health problems and disabilities co-occurring alongside LD (sensory impairments, dementia).	NICE (2012) NICE (2015) NICE (2016) SIGN (2016) BPS (2015b)

	DOMAIN	SUPPORTING POLICIES AND GUIDANCE
3.6*	Understanding the impact of having an LD across the lifespan which may include psychosocial sequelae at various times including but not limited to diagnosis and intervention during the childhood years, transition during late teenage and early adult years, adulthood and older age.	
3.7*	Understanding of the different contexts which people with learning disabilities may be a part (i.e. the family, special and mainstream education and school or colleges; day centres; vocational and employment opportunities, supported living schemes and residential care; and specialist care settings such as inpatient, mental health and forensic settings).	NHSE (2015a)
3.8*	Ability to communicate, both face to face and in written/ pictorial form with people from across the whole spectrum of communication abilities, including individuals who are nonverbal, together with an awareness of communication uses and mediums to facilitate accessible communication.	
3.9	Understanding of power differences between professionals and people who are marginalised or disempowered due to cognitive or communication deficits and how to address these in practice.	
3.10*	Ability to adapt psychological assessments and interventions to the cognitive, communications, sensory, social and physical needs of people with learning disabilities and their networks. Ability to provide consultation about adaptations to mainstream services to support inclusion.	Beail (2016)
3.11*	Ability to understand and respond to behaviour that challenges in order to support people locally and reduce the likelihood of out of area placements. Demonstrating competency in PBS including values, theory and process of the approach. Including carrying out a detailed functional assessment/analysis of behaviour and translating the results into guidance. Ability to work with networks to implement this guidance and recognise barriers to implementation.	DoH (2012) NICE (2015) PBS Academy (2015)

	DOMAIN	SUPPORTING POLICIES AND GUIDANCE
3.12	Understanding the need to reduce restrictive practices (including medication). Ability to use psychological theory and formulation (for example PBS) to aid risk assessment and risk management to inform multi-agency care planning when necessary.	BPS (2018) DoH (2007, 2014) NHSE (2016) PBS Academy (2015)
3.13	Ability to develop multi-faceted formulations (drawing on relevant psychological theory and evidence) and design interventions which take into account individual, systemic organisational and wider socio-political factors.	BPS (2011) Johnstone & Boyle (2018)
3.14	Ability to work with and provide leadership to a range of disciplines and agencies including health, social services, education, the voluntary and private sectors.	BPS (2010)
3.15	Understanding of the potential vulnerability of adults from marginalised groups, knowledge of safeguarding policies and procedures, and the ability to recognise signs of possible abuse.	MCA (2005) NHSE (2015b) BPS (2017b) Care Act (2014) ASP Act (2007)
3.16	Understanding capacity and consent issues, ability to obtain informed consent and to contribute to multidisciplinary assessments relevant to capacity and take part in best interest decisions when appropriate and necessary.	BPS (2019a, 2019b)
3.17	Ability to consult diverse staff teams and adapt the communication of psychological theories and interventions to recipients' needs.	BPS (2010)
3.18	Ability to contribute to service development.	BPS (2010)
3.19	Ability to design and deliver teaching and training that is clear, effective and closely matched to learners' needs.	

4. MECHANISMS FOR ACHIEVING THESE COMPETENCIES

All clinical psychology training programmes should ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 ACADEMIC TEACHING

The Faculty believes that each academic programme must have a specialist intellectual disability (ID) component which covers knowledge and skills specific to work with people with intellectual disabilities. Ideally each programme would have a lead within the programme team or within local services to co-ordinate the ID components of the curriculum. This is in addition to maximising opportunities within the rest of the programme curriculum for integrating thinking about working with people with intellectual disabilities, alongside other client groups in relation to specific clinical and contextual issues. Examples of this could include thinking about how the Mental Capacity Act (2005) applies to different client groups, or how to adapt different psychological therapies.

Specialist and integrated cross-speciality teaching which addresses the needs of people with intellectual disabilities should be developed and reviewed in regular consultation with the regional Faculty for Intellectual Disabilities group to reflect the views and needs of services at both a local and national level. Skills-based teaching should be delivered by clinicians specialising in the area of intellectual disabilities. Where possible opportunities for teaching provided by other members of multi-disciplinary teams (e.g. occupational therapists, speech and language therapists, psychiatrists, nurses) should be included where relevant in order for trainees to better understand the roles and function of different professionals, in the context of working with people with intellectual disabilities. Training programmes should involve service users and carers directly in designing the curriculum and delivering teaching (this is covered in more detail in Section 5).

Since the last publication of this document there have been a number of new policies and guidelines which are relevant to working with people with intellectual disabilities. It is important that all training programmes ensure that academic teaching is flexible enough to be able to accommodate such changes and updates in a timely fashion.

Of particular note is the emphasis on decolonising the curriculum. The BPS has encouraged the need to think more widely than the current dominant Eurocentric academic model and to integrate diversity and inclusion wherever possible (see for example *The Psychologist*, March 2020). Within teaching on ID modules, there may be specific opportunities to do this. When teaching about eligibility to services, lecturers can convey that the creation of IQ tests was rooted in the eugenics movement and included racial stereotypes. There is also a need to consider how intellectual disability is understood within non-Western countries and the intersectionality between disability and race. Alongside these specific examples, decolonisation should not be seen as a separate topic and efforts should be made to integrate diversity throughout the whole of the teaching (Patel et al., 2020).

The Faculty recommends that each programme should cover the following areas as a minimum, either through specialist and/or integrated cross-speciality teaching. The method of teaching could take a variety of formats for example, lectures, seminar groups, self-directed study and e-learning.

- The historical context of the lives and services for people with intellectual disabilities, including the historical constructions of 'learning disability' and other diagnostic labels.

- The current social and political context of the lives and services for people with intellectual disabilities.
- Relevant policies and guidance that applies to people with intellectual disabilities.
- Power differences between professionals and people with intellectual disabilities and how to address these in practice and research.
- The theory and critical appraisal of the applied practice of neuropsychological and adaptive functioning assessments.
- Critical awareness of the debates around 'best practice' in establishing eligibility for intellectual disability services.
- A biopsychosocial understanding of the mental health needs of adults with intellectual disabilities including the impact of different genetic disorders, as well as social context (e.g. marginalisation and the effects of stigma throughout a lifetime).
- A lifespan approach to understanding attachment and trauma informed care.
- The physical health needs of people with intellectual disabilities and an understanding of how health inequalities impact people with intellectual disabilities (e.g. understanding of programmes such as Stopping Over-Medication of People with a Learning Disability (STOMP) and the Learning Disabilities Mortality Review (LeDeR; www.bristol.ac.uk/sps/leder).
- How to adapt assessments and interventions across a range of therapeutic approaches to the needs of people with intellectual disabilities and their carers (family and/or paid carers).
- Assessment and intervention for behaviour that challenges services, including functional assessment and positive behaviour support (PBS).
- Teaching on pica and associated health risks, including mortality (specifically requested by the BPS in response to the inquest of the death of James Frankish in 2016 as a result of eating plant materials; see Shea et al., 2019a, 2019b).
- Autism spectrum disorders, including an understanding of different psychological theories, assessment and intervention.
- A range of methods suitable for evaluating a variety of psychological work with people with intellectual disabilities.
- Capacity and consent issues (including an understanding of the Mental Capacity Act (2005) and equivalent acts in devolved nations) and the implications for clinical practice and assessed work as part of the academic requirements of the programme.
- Supporting individuals with intellectual disabilities around relationships and sexuality (BPS, 2019c).
- Supporting parents who have intellectual disabilities.
- Dementia and people with intellectual disabilities, including best practice around assessment, diagnosis and intervention.
- Offending behaviour and forensic services for people with intellectual disabilities, with and without a diagnosis of ASD.
- The role of clinical psychology when working with people with profound and multiple intellectual disabilities and other co-morbid conditions, such as sensory impairments, physical impairments and epilepsy.
- Providing consultation to mainstream services around supporting the inclusion of people with intellectual disabilities and making reasonable adjustments.

4.2 CLINICAL PLACEMENTS

The Faculty recognises that the competencies listed in Section 3 could be gained across a variety of clinical settings with a range of clients. It remains the position of the Faculty that in order for trainees to be able to integrate their knowledge, skills and clinical experiences trainees should, wherever possible, gain substantial experience within the context of a team for people with intellectual disabilities. A brief survey of the training programmes found that the majority of programmes who responded to the survey (12 of 14 programmes who responded) still offer a dedicated placement with children or adults with intellectual disabilities, in order to meet these competencies (personal communication via email with intellectual disabilities module convenors leads within training programmes, February 2018). The Faculty do however recognise that this is not always possible for all training programmes to achieve, despite their best efforts, due to geographical and service constraints. Where this is the case training programmes in conjunction with regional supervisors should jointly ensure that arrangements are in place that allow trainees to gain a thorough understanding of the context, heterogeneity and complexity of the client group in order to demonstrate that they have met the competencies that are outlined in Section 3.

During the course of training, trainees supervised experience should include, wherever possible, the following in any clinical setting that can offer the opportunities to gain the relevant competencies:

- Working with a mix of presenting issues relevant to people with intellectual disabilities, in a variety of service settings across the lifespan.
- Working with people across the spectrum of intellectual disabilities, including people with severe and profound intellectual disabilities, to those with mild intellectual disabilities who may be seen in mainstream services.
- Work related to someone whose behaviour is constructed as 'challenging' including a comprehensive functional assessment and development and implementation of a positive behaviour support plan.
- Work related to someone with an autistic spectrum disorder.
- Detailed psychological assessment, including the use of formal measures (e.g. psychometric or functional assessment) which should at least be partly completed directly with the person with an intellectual disability.
- At least one direct assessment and intervention involving a person with an intellectual disability.
- A least one dementia assessment with a person with an intellectual disability.
- At least one assessment and intervention with family or paid carers, which could include indirect work with a staff team.
- Formal evaluation of the impact of a piece of psychological work (this should be encouraged across all pieces of work undertaken in conjunction with local policy).

The Faculty recognises that some high quality, yet very specialist placements may not provide the range of experiences outlined above. It is intended that these recommendations can be used as a template to guide programme staff, supervisors and trainees, in how to acquire the relevant experience to meet the competencies outlined. The Faculty believes that this is essential to developing a skilled and confident workforce to provide services to people with intellectual disabilities. Through this, it is hoped that services and outcomes for people with intellectual disabilities will improve.

It is expected that in fulfilling the above competencies, trainees will gain substantive experience with people with intellectual disabilities across the course of their training. The precise meaning of 'substantive experience' should be judged on an individual trainee basis. It will be incumbent upon

programmes and trainees to monitor the development of these competencies across the course of training, and tailor placement needs accordingly to ensure these are met by the end of training. The competencies may be gained through work with quite a number of different clients across one or more placements, or through more in-depth work with fewer clients, supplemented by additional observation, discussion and reflection. The range and types of experience outlined above are of course not mutually exclusive, and several may be addressed through in-depth work with the same individual or care system. Appendix A also outlines the mandatory competencies as outlined by the BPS (BPS, 2019a) which are likely to be obtained in a learning disability placement.

5. GOOD PRACTICE EXAMPLES

As part of the update to this good practice guidance, we sought recent examples of innovative practice involving people with intellectual disabilities and their families in clinical psychology training. These examples can be seen in Appendix 2. It is important to note that these examples are far from exhaustive, and other programmes may also be developing similar or different ways of involving people with intellectual disabilities, and their families and supporters, in delivering clinical psychology training. The Faculty strongly advocates for clinical psychology programmes to ensure that people with lived experience of intellectual disabilities are involved in delivering training, but appreciate that as programmes will be operating in varied contexts, how this involvement takes place will likely need to be adapted to meet the needs of individual programmes. Therefore, Appendix 2 serves as some examples of different types of practices for programmes wishing to review or expand their involvement of Experts by Experience in delivering training.

Appendix 1

List of required learning outcomes (BPS, 2019a) that LD services typically offer

ASSESSMENT (SECTION 2.1.3.2 C)

Assessment procedures in which competence is demonstrated will include:

- Performance based psychometric measures (e.g. of cognition and development).
- Self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours).
- Systematic interviewing procedures.
- Other structured methods of assessment (e.g. observation, or gathering information from others).
- Assessment of social context and organisations.

FORMULATION (SECTION 2.1.3.3)

e. Capacity to develop a formulation collaboratively with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

f. Making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

g. Ensuring that formulations are expressed in accessible language, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

PSYCHOLOGICAL INTERVENTION (SECTION 2.1.3.4)

b. Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

l. Implementing interventions and care plans through, and with, other professions and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

PERSONAL AND PROFESSIONAL SKILLS AND VALUES (SECTION 2.1.3.7)

a. Understanding of ethical issues and applying these in complex clinical contexts, ensuring that informed consent underpins all contact with clients and research participants.

b. Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.

c. Understanding the impact of differences, diversity and social inequalities on people's lives, and their implications for working practices.

COMMUNICATION AND TEACHING (SECTION 2.1.3.8)

a. Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

b. Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

c. Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

ORGANISATIONAL AND SYSTEMIC INFLUENCE AND LEADERSHIP (SECTION 2.1.3.9)

a. Awareness of the legislative and national planning contexts for service delivery and clinical practice.

d. Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross professional teams. Bringing psychological influence to bear in the service delivery of others.

e. Understanding of leadership theories and models, and their application to service development and delivery. Demonstrating leadership qualities such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.

SUPERVISED PRACTICE (CLINICAL EXPERIENCE AND SKILLS) (SECTION 2.1.4.2)

Service users: A fundamental principle is that trainees work with clients across the lifespan, such that they see a range of service users whose difficulties are representative of problems across all stages of development. These include:

- A wide breadth of presentations – from acute to enduring and from mild to severe.
- Problems ranging from those with mainly biological and/or neuropsychological causation to those emanating mainly from psychosocial factors.
- Problems of coping, adaptation and resilience to adverse circumstances and life events, including bereavement and other chronic, physical and mental health conditions.
- Service users with significant levels of challenging behaviour.
- Service users across a range of levels of intellectual functioning over a range of ages, specifically to include experience with individuals with developmental Intellectual disability and acquired cognitive impairment.
- Service users whose disability makes it difficult for them to communicate.
- Service users from a range of backgrounds reflecting the demographic characteristics of the population. Trainees will need to understand the impact of difference and diversity on people's lives (including sexuality, disability, ethnicity, culture, faith, cohort differences of age, socio-economic status) and their implications for working practices.

MODELS AND TYPE OF WORK (SECTION 2.1.4.4)

Trainees should:

- Undertake assessment, formulation and intervention both directly and indirectly (e.g. through staff, carers and consulting with other professionals delivering care and intervention); work within multidisciplinary teams and specialist service systems, including some observation or other experience of change and planning in service systems.

Trainees' work will need to be informed by a substantial appreciation of the legislative and organisational contexts within which clinical practice is undertaken.

Appendix 2

Examples of innovative practice from DClinPsy Training Programmes

LANCASTER UNIVERSITY

MEANINGFUL INVOLVEMENT OF PEOPLE WITH ID AND AUTISM IN THE LANCASTER DCLINPSY SELECTIONS PROCESS

Public participation in all aspects of programme activity is a core value for the Lancaster DClinPsy Programme. Involvement has to be meaningful and also appropriate for the ability level of the individual. At Lancaster we have developed two key areas to enable people with ID and autism to take part in our selections process which are outlined below.

MEET AND GREET HOSTS

Volunteers with ID and autism work alongside first year trainees to welcome candidates as they arrive and show them to the candidate base room. Hosts chat with candidates while they are waiting for their interviews, take a photo of each candidate and help prepare a folder for each candidate. Hosts undertake training which involves role playing the different tasks and also have easy read prompt sheets to remind them on selections days. Hosts are also asked to confidentially share impressions of the candidates with members of the programme team, including standard of interpersonal interaction. Giving feedback is covered with the hosts in their training and who to speak to if they feel upset or unhappy with any aspect of the process.

TOWER TASK (TT) PANEL MEMBER

This role has been introduced more recently and involves people with ID and autism being active participants in the interview panels. TT panel members join the interview panels for part of the interview and undertake a task directly with a candidate in front of the panel. They give feedback on the experience which is incorporated as evidence of candidate ability. The task allows insight into how candidates use their authority, interpersonal skills, ability to adapt communication and skills of engagement and enablement.

TT panel members are asked to attend a training session prior to the selections day. This includes consideration of what a clinical psychologist is and what makes a 'good' clinical psychologist; what the 'tower task' is and how to do it; how to enable candidates to show their skills (i.e. not jumping in and showing candidates how to build a tower); how to give feedback and what to do if a candidate is not very nice.

We have a dedicated paid co-ordinator on the selections days who is the 'go to' person for hosts and TT panel members. This has worked well and takes the pressure off programme staff who are occupied with other roles on selections days.

All volunteers are paid travel expenses and have refreshments/lunch on the selections days. Feedback from hosts and TT panel members about taking part has always been positive. Typically comments have included feeling valued, being taken seriously, feeling listened to, being a part of the team and that it has increased confidence in being able to speak to/be with people. From a programme perspective we value our hosts and TT panel members as being part of the selections team and the opportunity for ourselves, our trainees and colleagues from around the north west to work alongside people with ID and autism as peers. It is particularly great to observe the relationships between everyone involved grow year on year with acquaintances being renewed.

Dr Emma Munks
Senior Clinical Tutor
www.lancaster.ac.uk/health-and-medicine/dhr/dclinpsy
Bath DClinPsy Meaningful Involvement of People with ID in teaching

UNIVERSITY OF BATH

CHILDREN AND YOUNG PEOPLE WITH ID: CO-TAUGHT WORKSHOP

During the second year of training there is a half-day session provided for trainees which is co-facilitated by a group of young people with intellectual disabilities. The young people present information about themselves and ideas about what they feel makes a good therapist. There is then an opportunity for small group work for the young people and trainees to get to know each other, followed by a large group reflection on the session. The young people stay for a shared lunch with the trainees, and are also offered a tour of the university campus. The session was included in the 2018 Bristol Experts by Experience and Faculty for People with Intellectual Disability Conference looking at young people with ID working in partnership with clinical psychologists. Quotes from trainees are given below:

'It was just helpful to just spend time getting to know them with no pressure to do therapy, but get to know them and get some experience around a range of therapy.'

'It was great hearing what young people wanted from workers, to have a chance to engage with young people without pressures of "therapy" or an "agenda".'

'It was fantastic to have service users involved in this session, was great to be able to spend time with them and also see how staff who knew them well communicate with them.'

'I really valued the knowledge and honesty of the young people.'

'Meeting the children was a lovely opportunity to interact – I was able to pick up a few ideas about communication difficulties, breaking the ice, etc. within this short space of time…'

'Having the children join us and share their experiences was definitely the highlight, and I learnt so much from them.'

'The young people did a great job, and were really impressive and brave talking to us.'

'I really enjoyed this lecture and it made me think about a possible elective within child LD which I hadn't considered before. I found the involvement of children with a learning disability was really helpful and really enjoyable.'

HISTORY OF INTELLECTUAL DISABILITIES: CO-TAUGHT SESSION

The second year trainees at Bath also have a half-day session looking at the historical context of the lives of people with intellectual disabilities. As well as theoretical content, this session includes an extended live interview with someone with intellectual disabilities which explores their experiences of key life events such as leaving school, trying to find work, receiving support and hopes for the future. The individual with learning disabilities is interviewed by a clinical psychologist who they know via services. The Bath course provide payment (including preparation time), travel expenses and lunch for all co-teachers with experience.

Lara Best, Cathy Randle-Phillips and Trainee Clinical Psychologists
Bath Clinical Practice Team and NHS Avon and Wiltshire
www.bath.ac.uk/psychology/clinical

UNIVERSITY OF GLASGOW

MEANINGFUL INVOLVEMENT OF PEOPLE WITH LD AND THEIR FAMILIES IN TEACHING

The University of Glasgow provides training for trainees aligned to different health boards to complete their placements, and for the majority of training, they attend one day of teaching per week. The first year of training and teaching focuses mainly on adult and older adult mental health. Moving into second year, trainees alternate between six month placements working with children and families and adults with learning disabilities (LD). Teaching begins at the start of second year and covers a wide range of topics focusing on these two population groups. There was a great variety of service user involvement throughout our LD teaching, such as talks, workshops and opportunities to meet and speak with services users. I found the inclusion of both people with learning disabilities and their carers/families an invaluable part of our academic teaching around working with people with an LD.

TALK FROM A PARENT WITH A SON WITH AN LD

A parent came to speak to us about her experience of having a son with an ID and her experience of services. Her son is now an adult and attended a day centre four days per week. I found this really helpful as she was talking not just from a mental health perspective but also from a social perspective. She discussed the challenges her family had faced, for example difficulties accessing sufficient support and funding, which helped me gain a wider understanding of the holistic needs that people with an LD experience. However, she also spoke about the many positives she had gained over the years. I thought she was truly inspirational and it was really useful to hear the ways in which services can help to improve the lives of families as a whole. The experience helped me to reflect upon the work I could do as a clinical psychologist to support both individuals with LD and their families.

TALK FROM A SERVICE USER WITH PRADER WILLI SYNDROME

A gentleman with Prader Willi syndrome presented a PowerPoint presentation about his life, alongside his support staff. It was useful to hear first-hand how Prader Willi affects people day to day, and it felt really empowering to see him stand and speak to a group of strangers with so much confidence. There was a real emphasis on this person's strengths and abilities and it was great to hear about the ways he contributed to service quality and development. It helped me to think about the ways we can challenge any stigma associated with having an LD and the importance of having activities that are meaningful in peoples' lives.

HALF DAY MEET AND GREET WITH LUNCH

We also had the opportunity to meet with a group of adult service users, who each told us a bit about themselves and then stayed for an hour for lunch. Having the opportunity to informally chat and interact was really helpful in that it created a safe place to begin to think about ways in which you can adapt your communication skills to suit other's needs. It also helped to lessen my anxieties about working with a new population and the whole morning made me feel really enthusiastic about starting my LD placement.

VIDEOS THROUGHOUT LECTURES

Lastly, throughout teaching the lecturers would often use videos, for example, videos of adapting behavioural activation for people with a learning disability and videos of people talking about their experience of living within a hospital setting. I found this really helpful for getting ideas about the kinds of practical adaptations you can make and how to adapt your communication style (e.g. matching your pace to theirs).

Overall, I think including people with learning disabilities really brought the teaching to life and for me it sparked a passion for working with this population. It was particularly helpful having the majority of this teaching before I started placement.

Mhairi Nisbet
Trainee Clinical Psychologist (2017–2020)
www.gla.ac.uk/postgraduate/taught/clinicalpsychology

ROYAL HOLLOWAY UNIVERSITY OF LONDON

SHARING PERSPECTIVES OF PEOPLE WITH LEARNING DISABILITIES: CO-FACILITATED TEACHING IN CLINICAL PSYCHOLOGY TRAINING AT ROYAL HOLLOWAY UNIVERSITY OF LONDON

At the start of their second year on the Doctorate in Clinical Psychology at Royal Holloway University of London, trainees move from the focus on adult mental health in the first year of teaching and clinical placements, into work with a broader range of clinical groups, including placements working with people with learning disabilities. From October 2016, at the start of the second year induction we included a co-constructed teaching session, involving people with learning disabilities from a disabled people's organisation, Hammersmith & Fulham Safety Net – People First. The goals of the session delivered by SNPF were: to help trainees to understand more about what it's like to live with learning disabilities, to improve communication skills, and to dispel myths and anxieties about working with people with learning disabilities. We used different teaching methods to achieve this including small group discussion tasks facilitated by SNPF members, for trainees to discuss topics such as 'hidden disabilities' and 'anxieties asking clients about learning disabilities needs'. These sessions set the context for the remainder of the learning disabilities teaching module.

TRAINEE FEEDBACK AND RECOGNITION

Since its implementation, each year trainees have given very positive feedback on the co-facilitated session. All trainees consistently report in their feedback forms that they feel the workshop helps them to develop their communication skills, and trainees' self-reported confidence in working with people with learning disabilities improves. Some of the qualitative feedback from trainees has included: 'A fantastic session – informative and inspiring!', 'Helpful to understand viewpoints we might not otherwise have known', 'It dispels stigma and myths about learning disabilities. Has made me enthusiastic about having a learning disability placement', 'Helpful with communication skills – safe space to ask questions about anxieties'.

The teaching was awarded a College Team Teaching Prize in 2017, with feedback that the committee liked the thoughtful, collaborative and inclusive practice that is of great benefit to students.

SHARING THE LEARNING

We have expanded the delivery of this teaching to other programmes including the MSc in Clinical Psychology at Royal Holloway and MSc in Forensic Psychology at Kingston, where it was also positively received by students: 'The workshop was well structured and very insightful. I really enjoyed listening to individual experiences'; 'I thought it was really helpful, really nice to have an interactive lecture, felt that I learnt more than a normal lecture!'

Collated feedback from the co-facilitated training session has been shared with the trainers, trainees, wider programme staff, our Service User and Carer Involvement Group, and NHS programme commissioners. The trainers and trainees made have made videos outlining how valuable this collaborative session has been, which have been shared more widely

to promote and share the learning, including with NHS programme commissioners, BPS DCP GTICP, and the broader Programme Service User and Carer Involvement Group and the wider group of Safety Net People First – Disabled People's Organisation.

Since its initial development, the teaching has been developed further to allow opportunity for direct practice of good communication skills through a skills-based exercise; practising explaining confidentiality and consent to an initial psychology session.

Samantha, Martin, Richie and John
Hammersmith & Fulham Safety Net
People First
Kate Theodore
Clinical Psychologist/ Lecturer
www.royalholloway.ac.uk/research-and-teaching/departments-and-schools/psychology/studying-here/clinical-doctorate

SALOMONS CENTRE FOR APPLIED PSYCHOLOGY (CANTERBURY CHRIST CHURCH UNIVERSITY)

Using drama to hear the voices of people with learning disabilities in academic teaching

At the end of the first year of teaching, trainees on the clinical psychology doctorate programme at Salomons Centre for Applied Psychology start the academic teaching to prepare them for their placements in the second year of the course. Trainees have alternating six months placements working with children and families and adults with learning disabilities. Involvement of people with learning disabilities in the teaching, particularly in the introductory lectures, prior to trainees going on placement has been well established within the course for a number of years.

AIMS OF THE INTRODUCTORY TEACHING SESSIONS

Through meeting people with learning disabilities and hearing about their experiences, it is hoped that trainees reflect on their own assumptions and ideas about people with learning disabilities and how this might impact on their practice. It is also a chance for trainees to understand more about the varied lives that people with learning disabilities live, their skills and abilities and about important issues that impact on them, such as health inequalities. It also creates an opportunity for trainees to meet people in a more relaxed and informal way, and to engage in joint creative tasks to promote adapting their communication skills and collaborative working, which they can transfer to their work on placement. It is also hoped that some of the creative ways of working in LD services are mirrored in the teaching methods.

HOW THIS IS ACHIEVED

At Salomons the Baked Bean Company (BBC) are involved in teaching every year. The BBC was founded in 1997, in South West London, to provide outstanding services for people with learning disabilities. They provide a number of classes including drama, music, theatre, singing, DJing, life skills and they also offer holidays. They have a group called 'Beans in Education' which is a touring drama group, made up of adults with learning disabilities, who travel around the country performing short plays designed to educate the audience about what living with a learning disability is really like. After completing lots of interactive exercises with trainees and facilitators to warm up, the actors perform their 'health bites' show, which discusses issues around health inequalities and accessing services.

We also have a person with a learning disability, Di Morris, who is part of Salomon's Advisory Group of Experts (SAGE). Di helps with teaching sessions on the module (including performing a play, with trainee volunteers, that she co-wrote with a previous member of staff about her experiences at school), speaking

about what having a learning disability means for her as well as what she thinks it's important for trainees to know, before they go on placement. Di also sits on interview panels for staff and trainee selection and contributes to the work of SAGE on various projects around service user and carer involvement in all aspects of the course.

TRAINEE FEEDBACK

'EXCELLENT day – a really good example of how to work collaboratively with service users to learn from them, and give them an opportunity to learn through working with us, in a fun and interactive way. The activities were enjoyable as well as thought provoking, and avoided the pitfalls of feeling awkward or tokenistic. Thanks to all at The Baked Bean Company for their enthusiasm and insights.'

'Brilliant and creative introduction to the area.'

'It was really great to hear from Di, such an insight and first-hand experience.'

'This was a really excellent introduction to the LD module. I particularly enjoyed the theatre production at the end of the day as it helped to bring important issues into the spotlight in a very engaging humorous way.'

'Really valuable to have service user there and she seemed to be genuinely involved rather than just tokenistic.'

'Great to have Di's perspective, and I LOVED the baked bean company – brilliant day.'

'A big thank you to Di for sharing her personal experiences about living with a learning disability. I found it moving to listen to and this was most useful part of the day for me and gave me lots to think about.'

'Baked Bean Company was excellent and inspiring.'

'This was such an awesome day! Thank you for putting so much careful thought into our learning and experiences and for making this so fun! We really enjoyed meeting you all and think the performances were just brilliant. What a talented bunch! We also really found it helpful hearing about how BBC has been helpful for you.'

'Just can't rate this day high enough, learning from people with LD in such a fun way but also contained material and thought provoking ideas needed. 20 out of 10.'

Di Morris
SAGE

Dr Julie Steel
Consultant Clinical Psychologist and Clinical and Academic Tutor
www.canterbury.ac.uk/study-here/courses/postgraduate/clinical-psychology-20-21.aspx

UNIVERSITY OF ESSEX

Introduction to the Intellectual Disability Module; Visit to Project 49

At the University of Essex the Intellectual Disability Module runs throughout the second year of training on the doctorate in clinical psychology programme. As with other modules, we were keen to include experts by experience and this led us to approach Project 49 in 2016 in the hope that they might be able contribute to the programme.

Project 49 is a busy and innovative community-based resource for adults with learning disabilities. They provide a range of activities to encourage healthy living and wellbeing and have developed several projects and partnerships within the local area to promote independence, confidence and positive engagement.

Project 49 is very much characterised by a 'can do' approach which has resulted in them

hosting a visit for our second year Trainees for five years running. This takes place at the beginning of the ID Module and has proved to be a popular day for all involved.

The format of these visits has varied but usually starts with Project 49 sharing information about the range of community events they are involved with (such as an annual Big Health Day, gardening projects, open mic sessions and art projects throughout the local area). This is followed by a large group activity where trainee psychologists and Project 49 attendees spend some time getting to know each other and sharing different aspects of their lives. A member of staff also participates in a question-and-answer session around their career experiences. At lunchtime, Project 49 have provided fantastic home cooked meals via their 'pop up kitchen'. The afternoon provides an opportunity for everyone to participate in more structured psychology-based activities, such as the 'Tree of Life' or learning techniques to cope with stress. In 2020, due to Covid restrictions, the event still went ahead as a virtual visit, making use of breakout rooms and even including some Project 49 attendees who were shielding at home.

Feedback from trainee psychologists about the day has been consistently positive; the visits have been described as an 'invaluable experience' which contribute significantly to the academic teaching that the programme provides. In particular, the warm and welcoming atmosphere has been commented on, as is the involvement of Project 49 Attendees in every part of the day. Trainees have also been impressed by the way that Project 49 continually 'gives back' to the local community and they have valued the opportunity to listen to members of staff talking about both the challenges and rewarding aspects of their work.

Prior to the visit many trainees have not had any personal experience of meeting an individual with learning disabilities and some have expressed feeling nervous before the day. However their feedback suggests that having the opportunity to socialise and interact on a more informal level helps to dispel any misconceptions, increase their confidence and generally raise enthusiasm for starting the ID placement.

We are very grateful for Project 49's input into the doctorate programme and hope that future visits will continue to be possible.

Dr Alison Spencer
Clinical Psychologist / Clinical Tutor
www.essex.ac.uk/courses/pr00880/1/professional-doctorate-clinical-psychology-d-clin-psych

REFERENCES

BBC (2020, 2 June). Coronavirus: Pandemic sees spike in learning disabled deaths. *BBC*. Retrieved from www.bbc.co.uk/news/disability-52891401

BBC (2019, 22 May). Whorlton Hall hospital abuse and how it was uncovered. *BBC*. Retrieved from www.bbc.com/news/health-48369500

Beail, N. (2016). *Psychological therapies and people who have intellectual disabilities*. Leicester: British Psychological Society.

British Psychological Society (2010). *Clinical Psychology Leadership Development Framework*. Leicester: Author.

British Psychological Society (2011). *Good Practice Guidance on the use of psychological formulation*. Leicester: Author.

British Psychological Society (2012). *Good practice guidelines for UK clinical psychology training providers for the training and consolidation of clinical practice in relation to adults with learning disabilities*. Leicester: Author.

British Psychological Society (2015a). *Guidance on the assessment and diagnosis of intellectual disabilities in adulthood*. Leicester: Author.

British Psychological Society & Royal College of Psychiatry (2015b). *Dementia and people with intellectual disabilities: Guidance on the assessment, diagnosis, interventions and support of people with intellectual disabilities who develop dementia*. Leicester: Author.

British Psychological Society (2017a). Positive behavioural support. *Clinical Psychology Forum, 290* [Special issue]. Leicester: Author.

British Psychological Society (2017b). *Incorporating attachment theory into practice: Clinical practice guideline for clinical psychologists working with people who have intellectual disabilities*. Leicester: Author.

British Psychological Society (2018). *Positive behaviour support: Committee and Working Group Position Statement, Faculty for People with Intellectual Disabilities, Division of Clinical Psychology*. Leicester: Author.

British Psychological Society (2019a). *Standards for the accreditation of doctoral programmes in clinical psychology*. Leicester: Author.

British Psychological Society (2019b). *What makes a good capacity assessment*. Leicester: Author.

British Psychological Society (2019c). *Capacity to consent sexual relations*. Leicester: Author.

British Psychological Society (2020). *The Psychologist, 33*(3).

Brownridge, D.A. (2006). Partner violence against women with disabilities: Prevalence, risk, and explanations. *Violence Against Women, 12*(9), 805–822.

Department of Health (2007). Services for People with Learning Disabilities and challenging behaviour or mental health needs: The Mansell Report (2nd edn). London: The Stationary Office.

Department of Health (2009). Valuing People Now: A three-year strategy for people with learning disabilities. London. Department of Health.

Department of Health (2012). Transforming Care: A National Response to Winterbourne View. London. Department of Health.

Department of Health (2014). Positive and Proactive care: Reducing the need for restrictive interventions. London: Author.

Department of Health, Northern Ireland (2020). https://www.health-ni.gov.uk/news/independent-review-muckamore-published.

Disability Discrimination Act (1995) http://www.legislation.gov.uk/ukpga/1995/50

Equality Act (2010) http://www.legislation.gov.uk/ukpga/2010/15

Heslop, P., Blair, P., Fleming, P. et al. (2013). *Confidential inquiry into premature deaths of people with learning disabilities (CIPOLD) – Final report*. Bristol: University of Bristol. Retrieved from www.bristol.ac.uk/cipold/fullfinalreport.pdf

Johnstone, L. & Boyle, M. with Cromby, J. et al. (2018). *The Power Threat Meaning Framework: Overview*. Leicester: British Psychological Society.

Martin, S.L., Ray, N., Sotres-Alvarez, D. et al. (2006). Physical and sexual assault of women with disabilities. *Violence Against Women, 12*(9), 823–837.

McManus S, Bebbington P, Jenkins R, Brugha T. (Eds.) (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Mencap (2007). *Death by Indifference*. London: Mencap.

Mencap (2012). *Death by indifference: 74 deaths and counting – A progress report 5 years on*. London: Mencap.

Mencap (2020). *My health, my life: Barriers to healthcare for people with a learning disability during the pandemic*. London: Mencap.

National Assembly for Wales (2010). *Mental Health (Wales) measure 2010*. Retrieved from www.legislation.gov.uk/mwa/2010/7/contents/enacted

National Institute for Clinical Excellence (2012). *Autism spectrum disorders in adults: Diagnosis and management* (CG142). London: Author.

National Institute for Clinical Excellenc (2015). *Challenging behaviour and learning disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges* (NG11). London: Author.

National Institute for Clinical Excellence (2016). *Mental health problems in people with learning disabilities: Prevention, assessment and management* (NG54). London: Author.

National LD Professional Senate (2015). *A briefing paper on service specifications and best practice for professionals, NHS commissioners, CQC and providers of community learning disabilities health team*. Retrieved from www.bild.org.uk/wp-content/uploads/2020/01/National-LD-Professional-Senate-Guidelines-for-CLDT-Specialist-Health-Services-final-4-Jan-2019-with-references.pdf

National LD Professional Senate (2019). *Delivering effective specialist community learning disabilities health team support to people with learning disabilities and their families or carers*. Retrieved from https://www.bild.org.uk/wp-content/uploads/2020/01/National-LD-Professional-Senate-Guidelines-for-CLDT-Specialist-Health-Services-final-4-Jan-2019-with-references.pdf

NHS England (2015a). *Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*. London: Author.

NHS England (2015b). *Safeguarding policy*. Retrieved from www.england.nhs.uk/publication/safeguarding-policy

NHS England (2016). *Stop the Over Medication of People with a Learning Disability (STOMP)*. London: Author.

NHS England (2020). *Covid-19 deaths of patients with a learning disability notified to LeDeR*. Retrieved from www.england.nhs.uk/publication/covid-19-deaths-of-patients-with-a-learning-disability-notified-to-leder

NHS Education Scotland (2015) The Matrix: A guide to delivering evidence-based psychological therapies in Scotland. Edinburgh: NHS Scotland.

NHS Education Scotland and Scottish Government (2017). *Transforming psychological: a knowledge and skills framework for the scottish workforce*. Edinburgh: NHS Scotland.

NHS Education Scotland (2017). *Supporting psychological wellbeing in adult with learning disabilities: An educational framework interventions for practitioners working with adults with learning disabilities in Scotland*. Edinburgh: NHS Scotland.

NHS Health Scotland (2017). *People with learning disabilities in Scotland: 2017 health needs assessment update report*. Edinburgh: NHS Scotland.

NHS Education Scotland (2016). *Equal health – An educational framework on health equalities for people with learning disabilities for all practitioners working with people with learning disabilities: A human rights-based approach*. Edinburgh: NHS Scotland.

Patel, N., Bennett, E., Dennis, M. et al. (2000.) *Clinical psychology: 'Race' and culture: A training manual*. Leicester: BPS Books.

Positive Behaviour Suppor Coalition UK (2015). *Positive behavioural support: A competence framework*. Retrieved from http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf

Public Health Wales (2017). *Matrics Cymru: Guidance for delivering evidence based psychological therapies in Wales*.

Rickard, W. & Donkin, A. (2018). *A fair supportive society: Summary report*. London: Institute of Health Equity.

Scottish Government (2013). *Keys for life strategy*.

Scottish Government (2018). *Coming home: A report on out-of-area placement and delayed discharge for people with learning disabilities and complex needs*.

Scottish Intercollegiate Guidelines Network (2016). *Assessment, diagnosis and interventions for autism spectrum disorders* (SIGN 145).

Shea, E., Frankish, M. & Frankish, S. (2019a) James Frankish and pica: Learning the lessons from his life and death. London: National Autistic Society. Retrieved from https://network.autism.org.uk/knowledge/insight-opinion/james-frankish-and-pica

Shea, E., Frankish, M. & Frankish, S. (2019b). *Understanding and managing pica*. London: National Autistic Society. Retrieved from https://network.autism.org.uk/knowledge/insight-opinion/understanding-and-managing-pica

Skelly, A., Samuel, J. & Barter, B (2019). An open letter to UK clinical psychology training course directors and Committee of Trainers in Clinical Psychology from the Division of Clinical Psychology, Faculty for People with Intellectual Disabilities. *Clinical Psychology Forum, 32*1. Leicester: British Psychological Society.

Skills for Care & Skills for Health (2014). *A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health*. London: Authors.

Social Care, Local Government and Care Partnership Directorate (2014). *Positive and proactive care: Reducing the need for restrictive interventions*. London: Department of Health.

Spencer, N., Devereux, E., Wallace, A. et al. (2005). Disabling conditions and registration for child abuse and neglect: A population-based study. *Pediatrics, 116*(3), 609–614.

Sullivan, P.M. & Knutson, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect, 24*(10), 1257–1273.

Verita Consultancy (2015). *Independent review into issues that may have contributed to the preventable death of Connor Sparrowhawk: A report for NHS England, South Region and Oxfordshire Safeguarding Adults Board*. London: Verita.

the british
psychological society
promoting excellence in psychology

St Andrews House
48 Princess Road East
Leicester LE1 7DR, UK

☎ 0116 254 9568 🖵 www.bps.org.uk ✉ info@bps.org.uk

Incorporated by Royal Charter Registered Charity No 229642

REP148/02.2021

Belfast Health and Social Care Trust

Guidelines for the Practice of Supervision

Psychological Services

Dr Sarah Meekin
Consultant Clinical Psychologist
Head of Psychological Services
Belfast Health & Social Care Trust

January 2013

INDEX

1. Summary

- All psychological practitioners working within Psychological Services must receive some form of monthly supervision.
- All supervisory relationships must be contracted.
- It is the responsibility of each practitioner to ensure that they receive supervision and to report any problems in this process.
- All practitioners receiving supervision must keep a logbook.
- All practitioners providing line management supervision must maintain records.
- Supervision arrangements and compliance with this policy must be reviewed at least annually as part of the PCP process.
- All practitioners providing supervision have a responsibility to ensure that they attain and maintain competence in this area via CPD.

2. Introduction

“It is expected that all clinical psychologists, at all stages of their career and in all work contexts, will engage in regular supervision of their own work (Division of Clinical Psychology, British Psychological Society, 2006).

Supervision is a mandatory activity for all members of the Health Professional Council and statutory as part of professional regulation. It is noted in the HPC documentation that “The registered Practicing Psychologist (clinical psychologist) must understand models of supervision and their contribution to practice” and “understand the value of reflective practice and the need to record the outcome of such reflection”. (HPC, Practitioner Psychologist, 2010)

Supervision is an essential component of good clinical practice as it identifies and meets the practitioners learning needs and ensures best practice. It is necessary for ensuring continuing professional development and professional regulation. It is vital for clinical accountability and governance.

The following guidance document regarding supervision has been informed and guided by the advice and guidelines issued by our professional and regulatory bodies (British Psychological Society, Division of Clinical Psychology and Health Professional Council), and by the governance arrangements existing within the Belfast Health and Social Care Trust.

This current guidance document aims to identify and to operationalise a set of basic, minimum standards with regard to supervisory practice that will be applicable to clinical psychologists and other psychological practitioners, working in the Psychological Services Department, practising in the differing specialisms within and/or managed by the Belfast Health and Social Care Services Trust.
As “Psychological Services” is predominately made up of psychologists, the guideline refers to “Psychologist” as the practitioner. However these are generic guidelines, which can be applicable across the service.
There are people working within the area of psychological services who are not psychologists but members of other professions. These members of other professions may follow these guidelines or their own profession’s guidelines. The guidelines on supervision that they follow should be discussed on an individual basis and must be agreed with their line manager.

3. Receiving Supervision

3.1 While the availability of supervision can be variable and determined according to need, all psychologists should be in receipt of supervision at a level appropriate to their role and responsibilities.

3.2 Formal supervision should be available on a regular basis, the **minimal requirement being that supervision takes place at least once a month**.

We recognise that all psychologists engage in the process of unscheduled supervision and whilst acknowledging the importance, and indeed necessity of this activity, this should not in any way replace the formal supervisory requirement.

3.3 All areas of a psychologist's work, be it clinical, consultancy, supervisory, research, educational, managerial, should be subject to supervision. However most will fall into either line management supervision or clinical supervision. At times the same individual may be providing both aspects of supervision and it is important to clarify the different roles these serve. Thus they will be considered separately.

3.4 Although all types of supervision may be provided to an individual psychologist by the same supervisor, the supervisor should ensure that there is an appropriate balance in terms of the time given to each.
There may be an advantage to undertaking clinical supervision separately from other forms of supervision to ensure that sufficient time is afforded to clinical supervision. We recognise, however, that for a variety of reasons such separation may not always be possible or viable.

Line Management Supervision

- Line management structures are organisationally determined, not professionally. However all Psychologists working within the Belfast Trust are managed by and accountable to the Head of Psychological Services, regardless of where they deliver their service.

- Line management supervision has a focus on appraisal and performance monitoring. It complies with issues of clinical governance and accountability. However it should also have a strong focus on staff care with regards to their wellbeing, workload, functioning within team, etc...

- The line manager carries responsibility for the quality of the service and will often lead on the agenda. However the aim is for the process to be as reciprocal as possible.

- Managerial Supervision involves:

    - Management of workload of supervisee including annual leave, sickness absence and discipline
    - The regular monitoring and review of a staff member's performance towards achievement of Trust, local and agreed personal objectives
    - The giving of constructive feedback on practice and performance – both acknowledging the positive and areas for development
    - A space for staff care
    - The planning of new tasks, setting objectives and standards and reviewing tasks
    - The identification of individual training and development and resource needs relating to tasks
    - Completion of Performance Appraisal

- Line management supervision is linked to target and goal setting and will include at least an annual Appraisal, which is currently carried out within the Personal Contribution Plan framework (PCP).

- Recording of this supervision is the responsibility of the line manager. A template Line management Supervision Contract is available (Appendix 1). It is anticipated that the Supervision Record Form (Appendix 4) could be used to record line management supervision sessions.

Clinical Supervision

- Clinical supervision is a form of experiential learning (Carroll, 2007). According to this learning model supervisees acquire competence by learning from experience through a necessary combination of four learning modes: reflection; conceptualisation (thinking); planning; and concrete experience (feeling and doing). Professional competence occurs when the supervisee is given regular opportunities within clinical supervision to apply all four modes to all aspects of the clinical task and client/therapist relationship.

- Clinical supervision is defined as:
  "The formal provision, by approved supervisors, of a relationship based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching and collaborative goal setting. The objectives could be measured by current instruments". (Milnes, 2007).

- For the purpose of this policy clinical supervision is defined as that supervision that relates to all clinical activity, direct or indirect.

- Clinical supervision provides a confidential (in so far as there are no concerns regarding fitness to practice and/or competence) reflective space to discuss the workload.

- There may on occasion be no suitably qualified psychologist available to provide clinical supervision to a specific psychologist within Belfast Health and Social Care Trust. The reason or circumstance for the absence of this supervision must be specified and an explanation provided as to why this psychologist's supervision needs cannot be provided within the Trust. Under these circumstances then it will be necessary to seek and to ensure supervision is provided, preferably by a suitably qualified psychologist from outside the Trust.

- In instances where no such suitable qualified psychologist is available to provide supervision either within or external to the organisation the practitioner should seek competent supervision from some other psychologist or recognised and accredited Professional, in agreement with his or her Departmental Head or Psychology Manager.

- Supervision can be provided in different formats, for example one to one supervision, peer group, group supervision with a lead supervisor, co-supervision. Supervision should be needs led and appropriate to the experience, clinical work and managerial responsibility of the supervisee.

- Newly qualified staff will require more frequent and regular supervision than more experienced staff. Thus weekly or fortnightly supervision is appropriate at this stage in a psychologist's career. However all Psychologists should receive some form of monthly supervision.

- A review of the supervisory arrangement should be carried out annually as part of the Personal Contribution Plan. Following this review the following information should be recorded:
    - Date of review
    - Issues raised regarding the supervision process and action or changes agreed.
    - Signatures of both parties

The annual review should include an open discussion on the supervisory relationship and both parties should have the option/opportunity to request a change in the arrangements.

- Where there are problems within the relationship which cannot be resolved within the supervisory process, either party should/can discuss the issue with their line manager, or service lead, or head of service, or with a member of the Governance Workstream.

- Supervision Contract

    - In line with BPS/DCP guidelines a detailed contract will be written up at the beginning of each new supervisory relationship. A pro-forma detailing the information required is found in Appendix 2. It is not mandatory to use this pro-forma, however any alternative should contain the same information.

    - This contract should be reviewed at least annually.

    - This has effect from 1st January 2012 and all established supervisory relationships need to address this new standard.

- Supervision Records

    - In line with BPS/DCP guidelines a supervision logbook should be kept. This record is the responsibility of the SUPERVISEE. Copies can also be retained by the supervisor. This should take the form of an overall record of supervision received (this would be available for audit), as well as a record of each individual session (this would be confidential). A pro-forma is available in Appendix 3&4. It is not mandatory to use this pro-forma, however any alternative should contain the same information

This logbook should include:

- Date and duration of sessions
- Minimal notes at least on content of supervision, decisions and agreed actions
- Records of reviews of supervision and outcomes.
- In some situations (eg risk issues) it would be good practice to record a discussion/agreement in the relevant client file.
- It is preferable if this is completed at the end of each session and signed by both supervisor and supervisee.
- Where possible unscheduled supervision should be recorded in the same format as formal, pre-arranged sessions.

4. Providing Supervision

4.1. All qualified Psychologists may regularly be expected or asked to provide supervision to a range of colleagues working within the NHS, most commonly:

- Affiliate Psychologists
- Trainee Clinical Psychologists
- Qualified psychologists
- Members of other professions

The time and frequency of such supervision may be variable depending upon the guidelines and requirements of other professions.

Becoming a supervisor is a developmental pathway. Guidance from the Division of Clinical Psychology would recommend that the supervisory role is not undertaken until the clinical psychologist has a minimum of two years experience in a clinical role. As a department we would recommend that all potential new supervisors attend the “New Supervisor” workshops run by the Clinical Psychology Training Course at Queen’s University Belfast. Agreements as to undertaking supervisory duties need to be confirmed with your line manager.

4.2 The provision of supervision carries training implications for all practising psychologists. It is recommended by the BPS that all psychologists providing supervision should undergo an introductory training course in supervision, where available. Where such training is not available psychologists new to the supervisory role should, if available, sit in for a number of sessions with an experienced supervisor to gain some experience of the process.

4.3 All supervisors, even the most experienced, should be able to demonstrate a continuing commitment to update their skills and knowledge in the area of supervision, where possible by attendance at appropriate and accredited supervisory courses or workshops.

4.4 Time should be made available for supervisors to attend appropriate introductory and advanced training courses.

4.5 All psychologists providing supervision should attempt to evaluate the quality of their supervisory practice by either:

- Seeking feedback on performance
- Appraisal of their competence via self appraisal or peer review.

4.6 All psychologists providing supervision should review, at least annually, their need and requirement for updated training. This should be done within the process of the Staff Development and Personal Contribution Plan.

4.7 It is becoming increasingly common for Clinical Psychologists to have line management responsibility or clinical responsibility for teams and services which are not under the general management of Psychological Services. In such cases, these Psychologists will also link and be accountable to the appropriate operational management structures within the Trust.

REFERENCES

1. Division of Clinical Psychology. Guidelines for CPD. September 2001.

2. Division of Clinical Psychology. Professional Practice Guidelines. BPS 2001.

3. Policy Guidelines on Supervision in the practice of Clinical Psychology. DCP Supervision Guidelines. BPS 2003.

4. Continued Supervision: Policy Document. BPS / DCP July 2006.

5. Milnes, D. L. (2009). Evidence-Based Clinical Supervision. BPS Blackwell

6. Carroll, M. (2007). Clinical psychology supervision. Clinical Psychology Forum, 174, 35-37.

7. HPC (2010) Standards of Proficiency: Practitioner psychologists

8. HPC Managing Fitness to Practice

Belfast Health and Social Care Trust

APPENDIX 1

LINE MANAGEMENT SUPERVISION CONTRACT: Psychological Services

Date ……

Between Supervisor…….

Supervisee……..……

Purpose

To ensure …… understands his/her role and responsibilities and:

- To enhance positive outcomes for people who use our services
- To encourage continuous professional development
- To support in managing the demands of the job
- To provide constructive feedback in a safe and appropriate manner
- To enhance evidence-based practice
- To safeguard standards of practice
- To ensure that health and well-being at work issues are addressed
- To promote anti-discriminatory practice
- To ensure financial governance and probity

Framework for Supervision

Frequency of Meetings: ……

Length of Sessions: ……

Location: ……

Responsibility for Recording (usually the line manager):

..…… ……
Any other issues to record:

Line Manager: ----------Supervisee----------Date----------

Belfast Health and Social Care Trust

APPENDIX 2

CLINICAL SUPERVISION CONTRACT: PSYCHOLOGICAL SERVICES

This contract was drawn up on (date):

Between Supervisee:
(print names)
and Supervisor

A copy of this contract will be held by both the Supervisor and Supervisee. This contract will change as and when necessary and with prior consultation.

Frequency / Length

- Supervision sessions will be held every _____. (Minimum 4 weekly)
- A minimum of _____will be available. If a supervision session is missed, the Supervisee takes responsibility to rearrange an alternative date as soon as possible.

Confidentiality

- It is accepted that the information discussed within this session is confidential, with respect to information shared by either person.
- However the bounds of confidentiality only exist in so far as there are no concerns regarding either practitioner's fitness to practice and / or competence.
- Both practitioners are entitled to have issues concerning the quality of his/her work to be overt and open to his/her involvement.

Supervisor's Responsibilities

- To make sure supervision sessions happen as agreed.
- To maintain confidentiality unless concerns arise as noted.
- To create a supervision file for each Supervisee containing any documentation relating to the supervision and to ensure securely stored.
- To ensure that Supervisee is clear about his/her role and responsibilities.
- To provide a safe place for the supervisee to reflect on his/her clinical practice.

Supervisor's Rights

- That supervision will be valued
- Supervisee will attend punctually and provide adequate notice re cancellations
- To confidentiality
- Supervisee will keep records in accordance with policy

Supervisee's Rights

- To uninterrupted time in a private venue.
- To Supervisor's attention, ideas and guidance.
- To receive feedback.
- To set part of the agenda.
- To ask questions.
- To expect Supervisor to carry out agreed action or provide an appropriate explanation, within an agreed time frame.
- To state when feels over/under worked.
- To have his/her development/training needs discussed and action agreed.
- To challenge ideas and guidance in a constructive way.
- To have confidential environment unless competence issues arise.

Supervisee's Responsibilities

- To arrange supervision
- To attend supervision on time
- To keep a supervision log which is shared with the supervisor
- To be proactive.
- To accept feedback positively.
- To update Supervisor and provide relevant information.
- To prepare for supervision, and to keep a copy of the supervision record in a secure location.
- To bring issues, concerns and problems.
- To maintain the agreement.

Conflict

- Every effort should be made to resolve any conflict, within supervision.
- In exceptional circumstances, where this cannot be achieved, either party has recourse to intervention via line manager, head of service, lead of governance workstream.

Recording Mechanisms

- The Supervisor and Supervisee agree notes of the session, which should be signed and dated, using the pro-forma provided.

Signed by: ..... Date: .....
(Supervisee)

Signed by: ..... Date: .....
(Supervisor)

Date of Review: _____

Actions: _____

APPENDIX 3

Belfast Health and Social Care Trust

SUPERVISION MONITORING FORM

Staff member ……...

Supervisor…….

Date/time	Completed	Cancelled (by whom)	Reason for cancellation	Alternative date	Formal/ Unscheduled	Individual / Peer /Other	Signature Supervisor	Signature Staff member

Belfast Health and Social Care Trust

APPENDIX 4

SUPERVISION SESSION RECORD

(*This form is to be completed for all supervision sessions)*

SUPERVISEE NAME:_____ **SIGNATURE:**_____

TYPE OF SUPERVISION: LINE MANAGEMENT / CLINICAL

Date of Supervision session:	
Review of previous supervision: what has been actioned?	
Main issues discussed. **Supervision methods used- Recordings, Role Play, Discussion, other**	
Action points and critical reflections	
Time spent discussing in supervision:	

Supervisor NAME:_____ **Supervisor SIGNATURE:**_____

Belfast Health and Social Care Trust

Guidelines for Continuing Professional Development

Psychological Services

Dr Sarah Meekin
Consultant Clinical Psychologist
Head of Psychological Services
Belfast Health & Social Care Trust

February 2015

Introduction

Continuing Professional Development (CPD) is “the professional and work related aspect of lifelong learning. It is an integral part of the process of adapting to change, and essential for maintaining and enhancing professionalism and competence” (BPS CPD Policy).

The Health and Care Professions Council defines CPD as “a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practice safely, effectively, and legally within their evolving scope of practice.”

CPD requirements are integral to the delivery of good clinical governance. They are also part of the requirements for HPCP registration and for compliance with a professional code of conduct.

CPD can provide benefits at a number of different levels, including:

- Helping to ensure that Practitioners are offering the most effective service to their clients
- Providing long term career prospects
- Providing documented evidence of a practitioner’s commitment to their profession and of their continued competence
- Ensuring best practice in an increasingly litigious climate
- Helping the employer/organisation to ensure professionals are capable, competent and well trained in order to effectively contribute to organisational goals and service provision
- Public accountability and reassurance

In considering CPD within Psychological Services, the following documents are considered key and practitioners should make themselves aware of these and of their requirements:

- HCPC: Continuing professional development and your registration
- HCPC: Your guide to our standards for continuing professional development
- BPS: Continuing Professional Development Policy
- DCP: Continuing Professional Development Guidelines

CPD should also form a part of the conversation within the BHSCT Personal Contribution Framework (PCF).

There may be other professional documents that may be relevant to staff within Psychological services (eg Nursing and Social Work Policies) and it is the responsibility of all staff to be aware of the requirements for personal professional registration and within their own professional bodies and codes of conduct.

Summary

- CPD is a professional expectation and an individual responsibility

- Practitioners are expected to:
    - Actively engage in CPD
    - Maintain a record of CPD
    - Apply learning from CPD to professional practice

- Maintenance of professional registration with HPCP is based to meeting their CPD standards.

- Dedicated time is recommended for CPD.
    - The BPS recommends between ½ -1 day per month
    - DCP recommends a minimum of 70 hours per year for those working full time
    - Some of this time should be employed time but both the BPS and DCP recognise that individuals also have personal responsibility to undertake and record CPD.

- CPD should include a range of formal and informal activities – examples of CPD activity can be found in both the BPS/DCP documents and HCPC Guides.

Standards of Conduct and Practice for

Social Workers

Working together.
Making a difference.

Northern Ireland Social Care Council

Introductory Notes

About Us

The Northern Ireland Social Care Council (the Social Care Council) was established in 2001 as the regulatory body for the social care workforce in Northern Ireland.

We regulate the workforce by maintaining a register and setting standards for the conduct, practice and training of social care workers to ensure that the quality of care provided to service users and carers is of a high standard.

'Social work' has been a protected title since 1st June 2005, with social workers required by law to register with the Social Care Council in order to be able to practise.

Our register is a public record that those registered have met the requirements for entry onto the register and have agreed to adhere to the standards of conduct and practice set by the Social Care Council.

'Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing.'

Global Definition of Social Work (International Federation of Social Workers and International Association of Schools of Social Work, 2014)

About the Standards

As part of its roles and responsibilities, the Social Care Council is required to produce and publish standards of conduct and practice expected of social workers and social care workers. This booklet contains the standards of conduct and practice for **social workers.**

The **standards of conduct** describe the values, attitudes and behaviours expected of social care workers in their day to day work.

The **standards of practice** outline the knowledge and skills required for competent practice.

Together, both sets of standards combine to provide a baseline against which a social care worker's conduct and practice will be judged.

The standards are binding on all social workers registered with the Social Care Council, irrespective of employment status or work setting. Your fitness to practise will be judged against these standards and failure to comply could put your registration at risk. If someone raises a concern about your conduct or practice, it will be considered against these standards when deciding if we need to take any action.

The standards are intended to reflect existing good practice and public expectations of the behaviour and practice of social workers. They form part of the wider package of legislation, regulatory requirements, practice standards and employers' policies and procedures that social workers must meet.

Social workers are professionally accountable for their practice which means that they are responsible for ensuring their conduct and practice does not fall below the standards set out in this document and that no action or omission on their part harms the wellbeing of service users or carers.

The standards provide social workers with clear criteria to guide their practice and to check that they are working to standard. They are intended to be a support to registrants in their day to day practice.

The standards provide service users and carers with a clear understanding of how a social worker should behave towards them and the standards of practice they can expect to receive.

Consistent application of these standards by social workers will benefit service users and carers.

Employers of social workers are expected to take account of the standards in making decisions about the conduct and competence of their staff.

To help you understand these standards, we have published a glossary of terms. We will also publish guidance from time to time to support and underpin the standards. Guidance will be available on our website: www.niscc.info.

Underpinning Values

The following values inform and underpin the standards of conduct and practice:

Social care workers must:

- Respect the rights, dignity and inherent worth of individuals
- Work in a person-centred way
- Treat people respectfully and with compassion
- Support and promote the independence and autonomy of service users
- Act in the best interests of service users and carers
- Uphold and promote equality, diversity and inclusion
- Ensure the care they provide is safe and effective and of a high quality

Standards of Conduct

1 As a social worker, you must protect the rights and promote the interests and wellbeing of service users and carers.

2 As a social worker, you must strive to establish and maintain the trust and confidence of service users and carers.

3 As a social worker, you must promote the autonomy of service users while safeguarding them as far as possible from danger or harm.

4 As a social worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

5 As a social worker, you must uphold public trust and confidence in social care services.

6 As a social worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

As a social worker, you must protect the rights and promote the interests and wellbeing of service users and carers.

Protecting the rights and promote the interests and wellbeing of service users and carers

This includes:

1.1 Treating each person as an individual;

1.2 Treating people with consideration, respect and compassion;

1.3 Empowering service users and carers to communicate their views, needs and preferences, taking account of their preferred language and form of communication;

1.4 Respecting and, where appropriate, representing the individual views and wishes of both service users and carers;

1.5 Supporting service users' right to control their lives and make informed choices about the services they receive;

1.6 Gaining consent as appropriate from service users before you provide care or services, in line with your employer's procedures and any statutory requirements;

1.7 Explaining your role, the purpose of your involvement and the reasons for any decision you make;

1.8 Respecting and maintaining the dignity and privacy of service users;

1.9 Treating service users and carers fairly and promoting equal opportunities;

1.10 Respecting diversity, beliefs, preferences, cultural differences and challenging discriminatory attitudes or behaviour.

As a social worker, you must strive to establish and maintain the trust and confidence of service users and carers.

Strive to establish and maintain the trust and confidence of service users and carers

This includes:

2.1 Being honest and trustworthy;

2.2 Communicating in an appropriate, open, accurate and straightforward way;

2.3 Being able to communicate clearly in the English language both verbally and in writing;

2.4 Respecting confidential information and clearly explaining agency policies about confidentiality to service users and carers;

2.5 Holding, using and storing records in line with organisational procedures and data protection requirements;

2.6 Being reliable and dependable;

2.7 Honouring work commitments, agreements and arrangements and, when it is not possible to do so, explaining why to service users and carers;

2.8 Declaring issues that might create conflicts of interest and making sure that they do not influence your judgement or practice;

2.9 Adhering to policies and procedures about accepting gifts and money, hospitality or services from service users and carers;

2.10 Refusing any loans of money or property from anyone in your care or anyone close to them;

2.11 Not engaging in practices which are fraudulent in respect of use of public or private monies.

As a social worker, you must promote the autonomy of service users while safeguarding them as far as possible from danger or harm.

Promote the autonomy of service users while safeguarding them as far as possible from danger or harm

This includes:

3.1 Promoting service users' independence and empowering them to understand and exercise their rights;

3.2 Using established processes and procedures to assess, respond to and manage dangerous, abusive, discriminatory or exploitative behaviour and practice;

3.3 Following practice and procedures designed to keep you and other people safe from violent and abusive behaviour at work;

3.4 Bringing to the attention of your employer or the appropriate authority, without delay, resource or operational difficulties that might get in the way of the delivery of safe care;

3.5 Informing your employer or an appropriate authority, without delay, where the practice of colleagues or others may be unsafe or adversely affecting standards of care;

3.6 Complying with employers' health and safety policies, including those relating to substance misuse;

3.7 Recognising and using responsibly with service users and carers, the power that comes from your work role.

As a social worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

Respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people

This includes:

4.1 Recognising that service users have the right to take positive risks and helping them to identify and manage potential and actual risks to themselves and others;

4.2 Following risk assessment policies and procedures to assess whether the behaviour of service users or others presents a risk of harm to themselves or other people;

4.3 Taking necessary steps to minimise the risks of service users' behaviour causing actual or potential harm to themselves or other people;

4.4 Ensuring that relevant colleagues and agencies are informed about the outcomes and implications of risk assessments in a timely and effective manner.

As a social worker, you must uphold public trust and confidence in social care services.

Uphold public trust and confidence in social care services

In particular you must not:

5.1 Abuse, neglect or harm service users, carers or colleagues;

5.2 Exploit service users, carers or colleagues in any way;

5.3 Abuse the trust of service users and carers or the access you have to personal information about them or to their property, home or workplace;

5.4 Form inappropriate personal relationships with service users;

5.5 Discriminate unlawfully or unjustifiably against service users, carers or colleagues;

5.6 Condone any unlawful or unjustifiable discrimination by service users, carers or colleagues;

5.7 Put yourself or other people at unnecessary risk;

5.8 Behave in a way, in work or outside work, which would call into question your suitability to work in social care services;

5.9 Use social media or social networking sites or other forms of electronic communication in a way that contravenes professional boundaries, organisational guidelines or the Social Care Council standards.

As a social worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

Be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills

This includes:

6.1 Meeting relevant standards of practice and working in a lawful, safe and effective way;

6.2 Taking personal and, where appropriate, collective responsibility for quality improvement and safety in line with your job role;

6.3 Being personally accountable for your actions and able to explain and account for your actions and decisions;

6.4 Maintaining clear and accurate records as required by procedures established for your work;

6.5 Informing your employer or the appropriate authority in a timely manner about any personal difficulties that might affect your ability to do your job competently and safely;

6.6 Informing the Social Care Council and any employers you work for at the first reasonable opportunity if your fitness to practise has been called into question. This includes ill-health that affects your ability to practise, criminal convictions, disciplinary proceedings and findings of other regulatory bodies or organisations;

6.7 Seeking assistance from your employer or the appropriate authority if you do not feel able or adequately prepared to carry out any aspect of your work, or you are not sure about how to proceed in a work matter;

6.8 Ensuring that if there is a conflict between the Social Care Council standards of conduct and your work environment, your first obligation is to the standards;

6.9 Helping service users and carers to make complaints where required, taking complaints seriously and responding to them or passing them to the appropriate person including your employer or the Social Care Council;

6.10 Making service users and carers aware of your responsibilities within the Social Care Council standards of conduct;

6.11 Being open and honest with people if things go wrong, including providing a full and prompt explanation to your employer of what has happened;

6.12 Co-operating with any investigation or formal inquiry into your conduct, the conduct of others, or the care or services provided to a service user where appropriate;

6.13 Working openly and co-operatively with colleagues and treating them with respect;

6.14 Taking responsibility for work delegated to you, recognising and working within the limits of your knowledge, skills and experience;

6.15 Recognising that you remain responsible for the work that you have delegated to other workers;

6.16 Recognising and respecting the roles and expertise of workers from other disciplines and agencies and working in partnership with them;

6.17 Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Social Care Council Post Registration Training and Learning Requirements in line with your job role;

6.18 Contributing to the learning and development of others.

Standards of Practice

1. **Manage your role as a professional social worker.**
2. **Maintain an up-to date knowledge and evidence base for social work.**
3. **Develop social work practice through supervision, consultation,reflection and analysis.**
4. **Practise competently within your area of practice.**
5. **Engage and participate with service users and carers.**
6. **Assess needs, circumstances, rights, strengths and risks in partnership with those involved and respond appropriately.**
7. **Use social work interventions to manage risk and improve outcomes for service users.**
8. **Develop yourself and others.**
9. **Practise in multidisciplinary and inter-agency contexts.**


As a social worker, you must manage your role as a professional social worker.

Manage your role as a professional social worker

This includes:

1.1 Practising safely and effectively within the context of your organisation, requirements of legislation and scope of practice, being able to balance accountability and autonomy;

1.2 Exercising authority and professional judgement as a social worker within the appropriate legal and ethical frameworks;

1.3 Managing competing or conflicting interests;

1.4 Recognising ethical issues, dilemmas and conflicts that arise in the context of social work practice and drawing on an appropriate knowledge base to inform professional judgements;

1.5 Reflecting on the impact of your own values and experiences on practice with different groups of service users and carers;

1.6 Demonstrating social work values and principles, including the promotion of rights, social justice, equality and inclusion;

1.7 Prioritising and managing your work effectively;

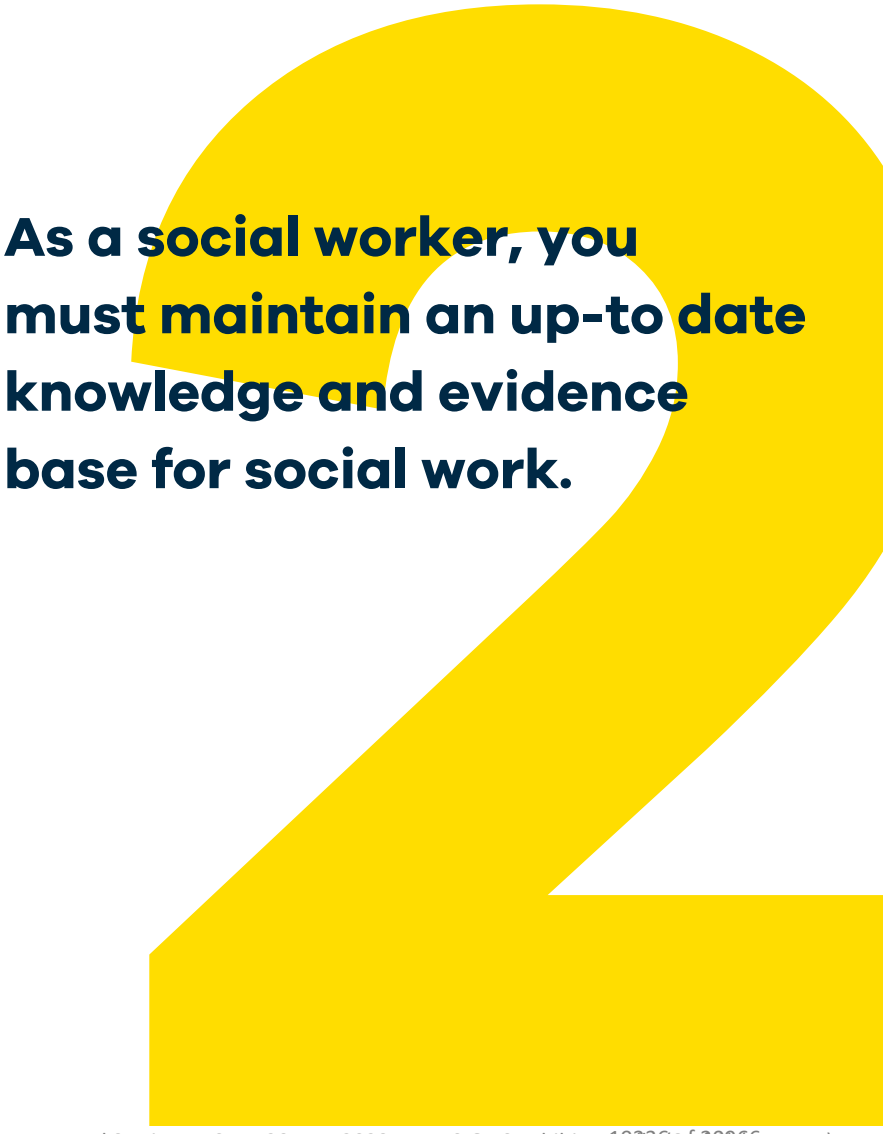
1.8 Constructing professional reports that are analytical, coherent and appropriate to the intended audience;

1.9 Maintaining accurate, complete, retrievable and up to date records that comply with applicable legal and organisational requirements;

1.10 Maintaining personal and professional boundaries;

1.11 Taking steps to ensure your own safety where there is a risk of harm;

1.12 Reporting any adverse events, incidents, errors and near misses that are likely to affect the wellbeing of service users or carers;



As a social worker, you must maintain an up-to date knowledge and evidence base for social work.

Maintain an up-to-date knowledge and evidence base for social work

This includes:

2.1 Taking responsibility for maintaining an up-to-date knowledge and evidence base for social work practice;

2.2 Working within the legislative and policy context for social work, including professional codes, standards, frameworks and guidance;

2.3 Updating your knowledge through research and evidence based practice, to inform your interventions;

2.4 Applying evidence-based knowledge and skills to practice.

As a social worker, you must develop social work practice through supervision, consultation, reflection and analysis.

Develop social work practice through supervision,consultation, reflection and analysis

This includes:

3.1 Applying critical thinking to reflect on practice;

3.2 Integrating learning into practice;

3.3 Accessing and using professional supervision appropriately in accordance with organisational and professional requirements;

3.4 Using supervision proactively by bringing your own ideas, suggestions and decisions for discussion;

3.5 Using feedback from supervision and other sources, including service users and carers, to inform reflection on and evaluation of social work practice.


As a social worker, you must practise competently within your area of practice.

Practise competently within your area of practice

This includes:

4.1 Clarifying and complying with legal and organisational requirements for your particular area of practice;

4.2 Fulfilling statutory responsibilities;

4.3 Demonstrating appropriate knowledge and skills for your particular area of practice;

4.4 Adapting your practice to meet specific needs of service users, carers, families, groups, and communities;

4.5 Developing your practice as needed to take account of new developments, research evidence or changing contexts;

4.6 Contributing to the continued improvement of social work practice, services, policies and procedures within your area of practice.


As a social worker, you must engage and participate with service users and carers.
5

Engage and participate with service users and carers

This includes:

5.1 Building and sustaining purposeful and situation appropriate professional relationships with service users and carers which are person-centred and inclusive;

5.2 Working in partnership to promote the active participation of service users and carers in all aspects of decisions and actions affecting their lives;

5.3 Supporting service users and carers to communicate their views, needs and preferences, advocating on their behalf where appropriate;

5.4 Where appropriate, challenging service users to achieve thei goals;

5.5 Clearly communicating your own and your organisation's roles and responsibilities;

As a social worker, you must be able to assess needs, circumstances, rights, strengths and risks in partnership with those involved and respond appropriately.

Assess needs, circumstances, rights, strengths and risks in partnership with those involved and respond appropriately

This includes:

6.1 Undertaking accurate, comprehensive and person centred assessments in line with agreed standards and procedures;

6.2 Assessing the nature, level, urgency and implications of any risks identified in compliance with legal and other requirements;

6.3 Making professional judgements about needs, risks and protective factors to inform planning, while balancing service users' rights and responsibilities;

6.4 Challenging resistance in the interests of achieving full information on which to assess risk;

6.5 Working in partnership with service users and carers to prepare, implement, monitor, review and revise plans to meet needs and circumstances, securing resources where required;

6.6 Supporting service users and carers to connect with appropriate resources and support to meet identified outcomes.

As a social worker, you must be able to use social work interventions to manage risk and improve outcomes for service users.

Use social work interventions to manage risk and improve outcomes for service users

This includes:

7.1 Having a sound knowledge of a range of evidence-based interventions and the ability to appropriately select and apply these to meet identified needs and circumstances of service users, families, carers, groups and communities;

7.2 Coordinating and facilitating a range of practical and emotional support, based on assessed need, to complement the service user's own resources and networks;

7.3 Developing and implementing risk management plans which promote independence and positive risk taking while taking account of legal and organisational requirements and service user capacity to make decisions regarding risks;

7.4 Identifying behaviours and environments that present potential risk of harm or abuse;

7.5 Reporting and investigating harm or abuse in line with regional safeguarding procedures, using persistence and assertiveness where required;

7.6 Promoting and supporting the safeguarding of service users in collaboration with multidisciplinary colleagues, adopting the east restrictive and least damaging plan of action to guarantee their safety and protection;

7.7 Being able to make a professional case for your assessment and recommendations where agreement is not reached and there is the potential for challenge from multidisciplinary colleagues and others;

7.8 Providing therapeutic support to service users who have experienced harm and/ or abuse;

7.9 Disengaging in a planned manner, providing service users and other agencies with information on the closure or continuity of support;

7.10 Arranging for the transfer or closure of information relating to social work involvement in line with agreed standards and procedures.

As a social worker, you must develop yourself and others.

Develop yourself and others

This includes:

8.1 Managing the physical and emotional impact of your practice and developing personal and professional resilience;

8.2 Keeping your knowledge, skills and competence up to date throughout your career, proactively seeking out learning and development opportunities that will meet your learning needs and priorities;

8.3 Taking responsibility for your continued professional registration and understanding what is required of you by your regulatory body;

8.4 Contributing to the learning, development and practice of others.


As a social worker, you must be able to practise in multidisciplinary and inter-agency contexts.

Practise in multidisciplinary and inter-agency contexts

This includes:

9.1 Developing and maintaining effective collaborative relationships with professionals from other disciplines and agencies;

9.2 Upholding and promoting the role and function of social work when working in a multidisciplinary context;

9.3 Understanding the roles and responsibilities of others and being able to negotiate respective responsibilities and deal constructively with disagreements and conflict;

9.4 Making and receiving referrals appropriately;

9.5 Ensuring the timely and effective exchange of information between professionals and agencies to inform assessments and promote the safeguarding and wellbeing of service users and carers.

Glossary

ACCOUNTABLE
Being responsible for the decisions you make and being able to justify them.

ADVERSE EVENT
Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

COMPETENCE
The overarching set of knowledge, skills and attitudes required to practise safely and effectively without supervision.

DIVERSITY
Accepting that everyone is different and respecting and valuing those differences.

EFFECTIVE
To be successful in producing a desired or intended result.

EMPOWER
To give someone the strength and confidence to act on their own initiative.

EQUALITY
Treating everyone fairly and ensuring they have access to the same opportunities irrespective of their race, gender, disability, age, sexual orientation, religion or belief.

FITNESS TO PRACTISE
When someone has the competence, character and health to do their job safely and effectively.

POST REGISTRATION TRAINING AND LEARNING REQUIREMENTS
These are the learning and development activities you must undertake to maintain your registration.

PREFERENCES
A person's preferred option or choice.

Glossary

PROMOTE
To support or actively encourage.

RESPECT
To have due regard for someone's feelings, wishes or rights.

RIGHTS
The entitlements that individuals have legally, socially and ethically, including human rights.

SERVICE USER
Any individual who receives social care services.

WELLBEING
Enjoying a good quality of life characterised by keeping well and healthy, feeling safe and secure, being able to participate in purposeful activities and social networks and realise one's full potential.

Notes:

Notes:

Notes:

Published on November 2015
Updated on August 2019

Northern Ireland Social Care Council
7th Floor, Millennium House
25 Great Victoria Street
Belfast BT2 7AQ
Tel : 02895 362 600
Web: niscc.info

Standards of Conduct and Practice for

Social Care Workers

Working together.
Making a difference.

Northern Ireland
Social
Care
Council

Introductory Notes

About Us

The Northern Ireland Social Care Council (the Social Care Council) was established in 2001 as the regulatory body for the social care workforce in Northern Ireland.

We regulate the workforce by maintaining a register and setting standards for the conduct, practice and training of social care workers to ensure that the quality of care provided to service users and carers is of a high standard.

Our register is a public record that those registered have met the requirements for entry onto the register and have agreed to adhere to the standards of conduct and practice set by the Social Care Council.

About the Standards

As part of its roles and responsibilities, the Social Care Council is required to produce and publish standards of conduct and practice expected of social workers and social care workers. This booklet contains the standards of conduct and practice for **social care workers.**

The **standards of conduct** describe the values, attitudes and behaviours expected of social care workers in their day to day work.

The **standards of practice** outline the knowledge and skills required for competent practice.

Together, both sets of standards combine to provide a baseline against which a social care worker's conduct and practice will be judged.

The standards are binding on all social care workers registered with the Social Care Council, irrespective of employment status or work setting. Your fitness to practise will be judged against these standards and failure to comply could put your registration at risk. If someone raises a concern about your conduct or practice, it will be considered against these standards when deciding if we need to take any action.

The standards are intended to reflect existing good practice and public expectations of the behaviour and practice of social care workers. They form part of the wider package of legislation, regulatory requirements, practice standards and employers' policies and procedures that social care workers must meet.

Social care workers are accountable for their practice which means that they are responsible for ensuring their conduct and practice does not fall below the standards set out in this document and that no action or omission on their part harms the wellbeing of service users or carers.

The standards provide social care workers with clear criteria to guide their practice and to check that they are working to standard. They are intended to be a support to registrants in their day to day practice.

The standards provide service users and carers with a clear understanding of how a social care worker should behave towards them and the standards of care they can expect to receive. Consistent application of these standards by social care workers will benefit service users and carers.

Employers of social care workers are expected to take account of the standards in making decisions about the conduct and competence of their staff. To help you understand these standards, we have published a glossary of terms. We will also publish guidance from time to time to support and underpin the standards. Guidance will be available on our website: www.niscc.info.

Underpinning Values

The following values inform and underpin the standards of conduct and practice:

Social care workers must:

- Respect the rights, dignity and inherent worth of individuals
- Work in a person-centred way
- Treat people respectfully and with compassion
- Support and promote the independence and autonomy of service users
- Act in the best interests of service users and carers
- Uphold and promote equality, diversity and inclusion
- Ensure the care they provide is safe and effective and of a high quality

Standards of Conduct

1. As a social care worker, you must protect the rights and promote the interests and wellbeing of service users and carers.

2. As a social care worker, you must strive to establish and maintain the trust and confidence of service users and carers.

3. As a social care worker, you must promote the autonomy of service users while safeguarding them as far as possible from danger or harm.

4. As a social care worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

5. As a social care worker, you must uphold public trust and confidence in social care services.

6. As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

As a social care worker, you must protect the rights and promote the interests and wellbeing of service users and carers.

Protecting the rights and promote the interests and wellbeing of service users and carers

This includes:

1.1 Treating each person as an individual;

1.2 Treating people with consideration, respect and compassion;

1.3 Empowering service users and carers to communicate their views, needs and preferences, taking account of their preferred language and form of communication;

1.4 Respecting and, where appropriate, representing the individual views and wishes of both service users and carers;

1.5 Supporting service users' right to control their lives and make informed choices about the services they receive;

1.6 Gaining consent as appropriate from service users before you provide care or services, in line with your employer's procedures and any statutory requirements;

1.7 Explaining your role, the purpose of your involvement and the reasons for any decision you make;

1.8 Respecting and maintaining the dignity and privacy of service users;

1.9 Treating service users and carers fairly and promoting equal opportunities;

1.10 Respecting diversity, beliefs, preferences, cultural differences and challenging discriminatory attitudes or behaviour.

As a social care worker, you must strive to establish and maintain the trust and confidence of service users and carers.

Strive to establish and maintain the trust and confidence of service users and carers

This includes:

2.1 Being honest and trustworthy;

2.2 Communicating in an appropriate, open, accurate and straightforward way;

2.3 Being able to communicate clearly in the English language both verbally and in writing;

2.4 Respecting confidential information and clearly explaining agency policies about confidentiality to service users and carers;

2.5 Holding, using and storing records in line with organisational procedures and data protection requirements;

2.6 Being reliable and dependable;

2.7 Honouring work commitments, agreements and arrangements and, when it is not possible to do so, explaining why to service users and carers;

2.8 Declaring issues that might create conflicts of interest and making sure that they do not influence your judgement or practice;

2.9 Adhering to policies and procedures about accepting gifts and money, hospitality or services from service users and carers;

2.10 Refusing any loans of money or property from anyone in your care or anyone close to them;

2.11 Not engaging in practices which are fraudulent in respect of use of public or private monies.

As a social care worker, you must promote the autonomy of service users while safeguarding them as far as possible from danger or harm.

Promote the autonomy of service users while safeguarding them as far as possible from danger or harm

This includes:

3.1 Promoting service users' independence and empowering them to understand and exercise their rights;

3.2 Using established processes and procedures to assess, respond to and manage dangerous, abusive, discriminatory or exploitative behaviour and practice;

3.3 Following practice and procedures designed to keep you and other people safe from violent and abusive behaviour at work;

3.4 Bringing to the attention of your employer or the appropriate authority, without delay, resource or operational difficulties that might get in the way of the delivery of safe care;

3.5 Informing your employer or an appropriate authority, without delay, where the practice of colleagues or others may be unsafe or adversely affecting standards of care;

3.6 Complying with employers' health and safety policies, including those relating to substance misuse;

3.7 Recognising and using responsibly with service users and carers, the power that comes from your work role.

As a social care worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

Respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people

This includes:

4.1 Recognising that service users have the right to take positive risks and helping them to identify and manage potential and actual risks to themselves and others;

4.2 Following risk assessment policies and procedures to assess whether the behaviour of service users or others presents a risk of harm to themselves or other people;

4.3 Taking necessary steps to minimise the risks of service users' behaviour causing actual or potential harm to themselves or other people;

4.4 Ensuring that relevant colleagues and agencies are informed about the outcomes and implications of risk assessments in a timely and effective manner.

As a social care worker, you must uphold public trust and confidence in social care services.

Uphold public trust and confidence in social care services

In particular you must not:

5.1 Abuse, neglect or harm service users, carers or colleagues;

5.2 Exploit service users, carers or colleagues in any way;

5.3 Abuse the trust of service users and carers or the access you have to personal information about them or to their property, home or workplace;

5.4 Form inappropriate personal relationships with service users;

5.5 Discriminate unlawfully or unjustifiably against service users, carers or colleagues;

5.6 Condone any unlawful or unjustifiable discrimination by service users, carers or colleagues;

5.7 Put yourself or other people at unnecessary risk;

5.8 Behave in a way, in work or outside work, which would call into question your suitability to work in social care services;

5.9 Use social media or social networking sites or other forms of electronic communication in a way that contravenes professional boundaries, organisational guidelines or the Social Care Council standards.

As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

Be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills

This includes:

6.1 Meeting relevant standards of practice and working in a lawful, safe and effective way;

6.2 Taking personal and, where appropriate, collective responsibility for quality improvement and safety in line with your job role;

6.3 Being personally accountable for your actions and able to explain and account for your actions and decisions;

6.4 Maintaining clear and accurate records as required by procedures established for your work;

6.5 Informing your employer or the appropriate authority in a timely manner about any personal difficulties that might affect your ability to do your job competently and safely;

6.6 Informing the Social Care Council and any employers you work for at the first reasonable opportunity if your fitness to practise has been called into question. This includes ill-health that affects your ability to practise, criminal convictions, disciplinary proceedings and findings of other regulatory bodies or organisations;

6.7 Seeking assistance from your employer or the appropriate authority if you do not feel able or adequately prepared to carry out any aspect of your work, or you are not sure about how to proceed in a work matter;

6.8 Ensuring that if there is a conflict between the Social Care Council standards of conduct and your work environment, your first obligation is to the standards;

6.9 Helping service users and carers to make complaints where required, taking complaints seriously and responding to them or passing them to the appropriate person including your employer or the Social Care Council;

6.10 Making service users and carers aware of your responsibilities within the Social Care Council standards of conduct;

6.11 Being open and honest with people if things go wrong, including providing a full and prompt explanation to your employer of what has happened;

6.12 Co-operating with any investigation or formal inquiry into your conduct, the conduct of others, or the care or services provided to a service user where appropriate;

6.13 Working openly and co-operatively with colleagues and treating them with respect;

6.14 Taking responsibility for work delegated to you, recognising and working within the limits of your knowledge, skills and experience;

6.15 Recognising that you remain responsible for the work that you have delegated to other workers;

6.16 Recognising and respecting the roles and expertise of workers from other disciplines and agencies and working in partnership with them;

6.17 Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Social Care Council Post Registration Training and Learning Requirements in line with your job role;

6.18 Contributing to the learning and development of others.

Standards of Practice

1 **Understand the main duties and responsibilities of your own role within the context of the organisation in which you work.**

2 **Be able to communicate effectively.**

3 **Deliver person-centred care and support which is safe and effective.**

4 **Support the safeguarding of individuals.**

5 **Maintain health and safety at work.**

6 **Develop yourself as a social care worker.**

As a social care worker, you must understand the main duties and responsibilities of your own role within the context of the organisation in which you work.

Understand the main duties and responsibilities of your own role within the context of the organisation in which you work

This includes:

1.1 Knowing the aims, objectives and values of the service in which you work;

1.2 Accessing full and up-to-date details of policies, procedures and agreed ways of working from your employer and adhering to them;

1.3 Knowing your main responsibilities to those service users and carers you support including duty of care;

1.4 Prioritising and managing your work effectively;

1.5 Working in partnership with key people, advocates and others who are significant to individual service users and carers;

1.6 Possessing the required level of literacy, numeracy and communication skills necessary to carry out your role and being able to communicate using written English;

1.7 Keeping records that are up to date, complete, accurate and legible;

1.8 Reporting any adverse events, incidents, errors and near misses that are likely to affect the quality of care and wellbeing of service users or carers;

1.9 Responding appropriately to comments and complaints in accordance with your organisation's complaints procedure.


As a social care worker,
you must be able to
communicate effectively.

Be able to communicate effectively

This includes:

2.1 Developing effective relationships with service users and carers;

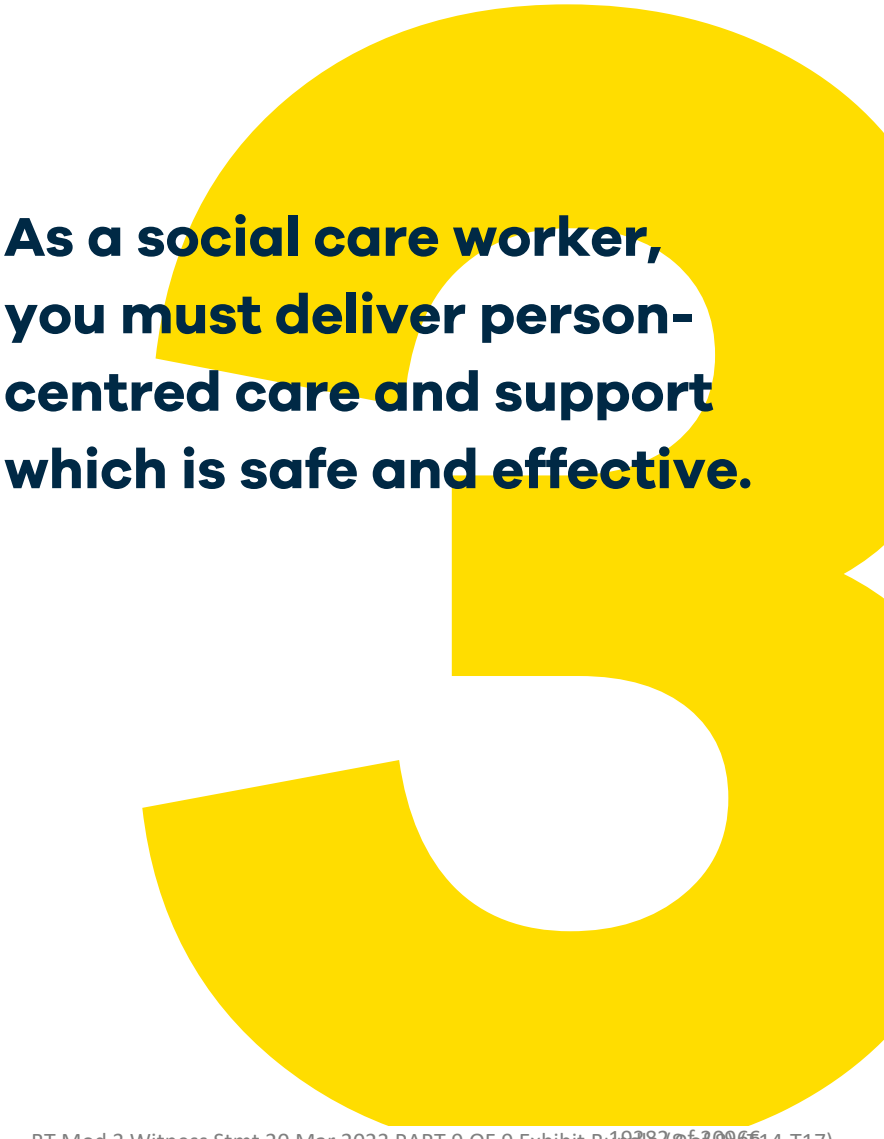
2.2 Establishing the service user's communication and language needs, wishes and preferences;

2.3 Using a range of communication methods and styles to meet a service user's communication needs, wishes and preferences;

2.4 Recognising and addressing barriers to effective communication;

2.5 Working effectively as part of a team, sharing relevant information to ensure the service user receives the best support and care possible;

2.6 Sharing information with other health and social care staff and agencies in a timely manner in line with organisational procedures and principles and practices relating to confidentiality.


As a social care worker, you must deliver person-centred care and support which is safe and effective.

Deliver person-centred care and support which is safe and effective

This includes:

3.1 Promoting and applying person-centred values in your day to day work with service users and carers;

3.2 Delivering care in line with assessed needs and service user and carer preferences;

3.3 Undertaking risk assessments appropriate to your role, in partnership with service users, carers and other key people;

3.4 Contributing to the risk assessment process by identifying and reporting risks and concerns;

3.5 Contributing to the planning process with service users and carers;

3.6 Working in partnership with service users to enable them to achieve their goals and be as independent as possible;

3.7 Developing care or support plans and/or risk management plans where appropriate, which promote independence in daily living while taking account of any legal or organisational requirements;

3.8 Contributing to the implementation of care or support plans and risk management plans;

3.9 Participating in the review of care or support plans and/or risk management plans where appropriate;

3.10 Supporting service users in their daily living;

3.11 Supporting service users to retain, regain and develop skills to manage their daily living;

3.12 Contributing to the physical and emotional well-being of service users and carers;

3.13 Enabling service users and carers to make informed choices about their lives and to actively participate in decision-making processes;

3.14 Supporting service users to develop and maintain social networks and relationships;

3.15 Contributing to effective group care where appropriate;

3.16 Ending your involvement with service users and carers in a planned way, ensuring that they are provided with information on the closure and any continuing forms of support for them.


As a social care worker,
you must support the
safeguarding of individuals.

Support the safeguarding of individuals

This includes:

4.1 Knowing the main types of abuse and the factors that may make a service user or carer vulnerable to harm or abuse;

4.2 Knowing the regional policies and procedures relating to safeguarding;

4.3 Knowing your own role and responsibilities in relation to safeguarding;

4.4 Recognising the signs and symptoms of harm or abuse when present;

4.5 Taking the appropriate actions to safeguard a service user or carer if you suspect they are being harmed or abused or if they disclose that they are being harmed or abused;

4.6 Reporting suspected or actual harm or abuse to the designated person in accordance with employer safeguarding policies.


As a social care worker,
you must maintain health
and safety at work.
5

Maintain health and safety at work

This includes:

5.1 Applying your organisation's policies and procedures in relation to health and safety in your work setting and with regard to the service users and carers you support;

5.2 Applying your organisation's policies and procedures in relation to medication and health care tasks;

5.3 Applying your organisation's policies and procedures in relation to moving and handling service users;

5.4 Knowing what you can and cannot do relating to general health and safety commensurate with your role and training;

5.5 Recognising the risks to your personal safety and wellbeing in your work setting and taking steps to minimise these.

As a social care worker, you must develop yourself as a social care worker.

Develop yourself as a social care worker

This includes:

6.1 Being aware of relevant standards that relate to your work role;

6.2 Evaluating your own knowledge, performance and understanding against relevant standards;

6.3 Reflecting on your practice to continuously improve the quality of service provided;

6.4 Using sources of support for your personal development, including supervision, appraisal and training;

6.5 Seeking and using feedback, including that from service users and carers to help you develop and improve the way you work;

6.6 Recording progress in relation to your personal development.

Glossary

ACCOUNTABLE
Being responsible for the decisions you make and being able to justify them.

ACTIVE PARTICIPATION
A way of working that recognises an individual's right to participate in the activities and relationships of everyday life as independently as possible and to be an active partner in their own care and support rather than a passive recipient.

ADVERSE EVENT
Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.

CARE PLAN
A written plan that sets out in detail the way daily care and support must be provided to an individual.

COMPETENCE
The overarching set of knowledge, skills and attitudes required to practise safely and effectively without supervision.

DIVERSITY
Accepting that everyone is different and respecting and valuing those differences.

DUTY OF CARE
Prioritising the safety, welfare and interests of service users and doing everything you can to keep them safe from harm.

EFFECTIVE
To be successful in producing a desired or intended result.

EMPOWER
To give someone the strength and confidence to act on their own initiative.

EQUALITY
Treating everyone fairly and ensuring they have access to the same opportunities irrespective of their race, gender, disability, age, sexual orientation, religion or belief.

Glossary

FITNESS TO PRACTISE
When someone has the competence, character and health to do their job safely and effectively.

INCLUSION
Ensuring that people are treated equally and fairly and are included as part of society.

NEAR MISS
An unplanned event that did not result in injury, illness or damage, but had the potential to do so.

PERSON-CENTRED VALUES
These include individuality, independence, privacy, partnership, choice, dignity, respect and rights.

POST REGISTRATION TRAINING AND LEARNING REQUIREMENTS
These are the learning and development activities you must undertake to maintain your registration.

PREFERENCES
A person's preferred option or choice.

PROMOTE
To support or actively encourage.

REFLECTIVE PRACTICE
The process of thinking about every aspect of your work, including how and where it could be improved.

RESPECT
To have due regard for someone's feelings, wishes or rights.

RIGHTS
The entitlements that individuals have legally, socially and ethically, including human rights.

SELF-CARE
Practices undertaken by service users towards managing health and wellbeing and managing their own care needs.

Glossary

SERVICE USER
Any individual who receives social care services.

WELLBEING
Enjoying a good quality of life characterised by keeping well and healthy, feeling safe and secure, being able to participate in purposeful activities and social networks and realise one's full potential.

Notes:

Notes:

Notes:

Published on November 2015
Updated on August 2019

Northern Ireland Social Care Council
7th Floor, Millennium House
25 Great Victoria Street
Belfast BT2 7AQ
Tel : 02895 362 600
Web: niscc.info

Northern Ireland Social Care Council

Post Registration Training and Learning (PRTL)

Continuous Learning & Development Standards

GUIDANCE

for Social Care Registrants

September 2020

Content

Appendices

Part 1: Introduction

About this document

This document is for social care workers, senior care workers and social care managers on the Northern Ireland Social Care Council Register.

The Northern Ireland Social Care Council Standards of Conduct and Practice for Social Care Workers state:

As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

There are different PRTL requirements for social care workers, senior care workers and for social care managers.

Definitions

SOCIAL CARE WORKER

The function of the social care worker is to provide service users with direct personal care, practical support and to work under direction and supervision.

SENIOR CARE WORKER

The function of the senior care worker is to provide supervision and appraisal of social care workers. Senior care workers may also be involved in the direct provision of care.

SOCIAL CARE MANAGER

The function of the social care manager is to provide a governance and accountability role for the overall operational management of the care provision, quality assurance of that provision and the supervision and appraisal of others.

Part 2: Post Registration Training and Learning (PRTL)

What is PRTL?

PRTL is the learning and development activities through which you maintain and develop your competence throughout your career and which helps you to:

- Improve the service for the people you support/care for
- Develop and improve your job skills, knowledge and behaviour
- Keep up to date with new practice developments, legislation and policy

Why is PRTL important?

Meeting Requirements

As a social care worker, you will undertake learning and development in your job. You must keep a record of all learning and development completed. As part of your registration with the Northern Ireland Social Care Council, this must meet the Northern Ireland Social Care Council PRTL requirements. This will ensure you meet minimum standards for your role.

Having a learning and development plan

You should have a plan for your learning and development, discussed and agreed with your manager. This should be reviewed annually.

Providing focus for your learning

The Northern Ireland Social Care Council Continuous Learning and Development Standards (Appendix 2) provide a focus for PRTL activity by specifying common standards to be met by all social care workers, alongside specific standards to be met by senior care workers and social care managers. Meeting these standards should ensure that your learning and development is relevant to your job and your knowledge and skills are kept up to date.

Providing a better service

Skilled and knowledgeable registrants provide a better service and this contributes to increasing the confidence of service users, their carers and the general public in social care services.

PRTL and Renewal of Registration

The Northern Ireland Social Care Council Registration Rules require social care workers, when renewing their registration, to confirm that they have completed a minimum of 90 hours training and learning.

Renewal timescales are:

SOCIAL CARE WORKER & SENIOR CARE WORKER
FIVE YEAR RENEWAL PERIOD

SOCIAL CARE MANAGER
THREE YEAR RENEWAL PERIOD

When you apply to renew your registration, the Northern Ireland Social Care Council will ask you to confirm that you have met the PRTL requirements of 90 hours' learning and development. PRTL is a mandatory element of renewal. Failure to meet this requirement may lead to referral to a Registration Committee and may call into question your fitness to practise.

Part-time workers

PRTL requirements are the same if you work part-time as for full-time colleagues (90 hours). Part-time staff should be given similar opportunities and support for their learning and development as full time staff.

Agency workers

There is a shared responsibility for the employment agency and the social care contractor to ensure you are fit and competent to practise. The contractor must ensure you are provided with opportunities to meet PRTL requirements, including supervision and support from a line manager.

Responsibilities of Social Care Registrants

As a social care registrant, you are responsible for:

1. Undertaking a minimum of 90 hours' PRTL in a registration period
    - 5 years for a social care worker/senior care worker
    - 3 years for a social care manager
2. Planning your PRTL - which may be a mixture of formal and informal learning, in the workplace and in your own time.
3. Having a written learning and development plan agreed and reviewed annually with your employer. This should link to the Northern Ireland Social Care Council Continuous Learning and Development Standards (Appendix 2).
4. Recording your learning and development. Keep a record of any training undertaken and keep a copy of any certificates of training. This is your responsibility.
5. If selected for audit, you must submit the Audit Submission Form to the Northern Ireland Social Care Council within the timescale if you wish to remain on the Northern Ireland Social Care Council register.

Responsibilities of Social Care Employers

As an employer, you are responsible for:

1. Providing induction, training and development opportunities to help registrants do their jobs effectively, and ensuring they are appropriately trained for their post within the context of the Continuous Learning and Development Standards.
2. Working with registrants on the development of a learning and development plan which is regularly reviewed. This plan should link to the Northern Ireland Social Care Council Continuous Learning and Development Standards.
3. Supporting registrants to record their learning and development.
4. Support registrants to submit the Audit Submission Form following an audit request from the Northern Ireland Social Care Council.

What do I need to do to meet the Continuous Learning and Development Standards?

SOCIAL CARE WORKER

Focus on the five Continuous Learning and Development Standards:

Principles of Care

Health and Safety

Social Care Skills

Communication

Safeguarding

SENIOR CARE WORKER

Focus on the five Continuous Learning and Development Standards, plus the standard on supervision and appraisal:

Principles of Care

Health and Safety

Social Care Skills

Communication

Safeguarding

Supervision/ Appraisal

SOCIAL CARE MANAGER

Focus on the five Continuous Learning and Development Standards, plus the standards on supervision and appraisal as well as leadership and management:

Principles of Care

Health and Safety

Social Care Skills

Communication

Safeguarding

Supervision/Appraisal

Leadership and Management

Your learning and development plan should link to the Continuous Learning and Development Standards that are specific to your job role (see diagram above) and (Appendix 2).

Much of your learning and development may be mandatory training which is required by the Regulation and Quality Improvement Authority (RQIA). This may be supplemented by a wide range of activities from formal training to learning from others, reading journal articles, or relevant viewing materials. For each activity, you need to think about how this learning will improve the service you provide and benefit the people you support/care for.

There are examples of PRTL activities in (Appendix 5). There is also a range of useful resources published by the Social Care Institute for Excellence (SCIE) which are available on their website at www.scie.org.uk.

You must keep a record of your learning and development (PRTL) activities and keep copies if moving between social care roles.

Part 3: PRTL Audit

The Northern Ireland Social Care Council is required to audit the PRTL activities undertaken by social care workers. This is to ensure the required standards for PRTL are being maintained across all sectors of social care employment.

Twice a year, the Northern Ireland Social Care Council selects a random sample of social care registrants to submit for audit. If you have completed a learning and development plan and kept evidence/records of learning undertaken, this will enable you to submit for audit. For social care workers, this requires a completed Audit Submission Form to be returned to the Northern Ireland Social Care Council (Appendix 3). Social care managers have a different form to submit (Appendix 4).

Examples of completed audit forms for social care workers and social care managers can be found at www.niscc.info.There are also learning points for social care registrants included from previous audit points.

What will happen if selected for Audit?

1. You will be contacted in writing advising you that you have been selected for audit and you have 90 days to submit.
2. You should advise your employer that you have been selected for audit.
3. You should complete the audit submission form for your role as social care worker or senior care worker (Appendix 3) and for social care managers (Appendix 4), and then return to the Northern Ireland Social Care Council within the timescale.
4. The Northern Ireland Social Care Council will assess your audit submission against the PRTL requirements.
    - The outcomes of your PRTL activity.
    - The Northern Ireland Social Care Council Standards of Conduct and Practice for Social Care Workers (Appendix 1).
    - The Northern Ireland Social Care Council Continuous Learning and Development Standards (Appendix 2).
5. If your audit meets the standards, you will receive a letter confirming competence.
6. If your audit does not fully meet the requirements, you will be given the opportunity to re-submit.
7. You must submit for audit if you wish to remain on the Northern Ireland Social Care Council register.

How to submit for audit:

Social Care Workers/ Senior Care Workers

- Gather your learning and development plan and evidence for PRTL.
- Advise your employer you have been selected for audit.
- Read examples of the Audit Submission Form at www.niscc.info.
- Complete the Audit Submission Form – (Appendix 3).
- Sign and date the form.
- Ask your manager to sign and date your form.
- Submit your form to the Northern Ireland Social Care Council.

Social Care Managers

- Gather your learning and development plan and evidence for PRTL.
- Advise your employer you have been selected for audit.
- Read examples of the social care managers Audit Submission Form at www.niscc.info.
- Complete the Audit Submission Form for Social Care Managers (Appendix 4).
- Sign and date the form.
- Ask your manager to sign and date your form.
- Submit your form to the Northern Ireland Social Care Council.

Exemption from Audit

Qualifications: if you have completed and hold a certificate for a qualification in social care that you have undertaken within the last five years, please contact registration@niscc.hscni.net or **call Customer Services on: 028 95362600** to check if you are exempt from audit.

Deferral due to exceptional circumstances

- It is important that every social care worker keeps their knowledge and skills up to date. It is appreciated there may be exceptional circumstances which are beyond your control that prevent you from submitting for audit.

- The Northern Ireland Social Care Council is prepared to consider requests for deferral of audit due to exceptional circumstances and in accordance with the Northern Ireland Social Care Council Registration Rules, as set out below:

- Rule 8 (9) The Council shall not refer a registrant to the Registration Committee, where that registrant has failed to complete the post registration training and learning requirements due to exceptional circumstances or where the registrant is on maternity, adoption or fostering leave.

- If you believe you will be unable to complete your audit due to maternity, adoption or fostering leave, or due to exceptional circumstances, you should contact the Northern Ireland Social Care Council Customer Services at least 20 days before your audit is due and request consideration of an extension.
  Contact: registration@niscc.hscni.net or telephone: 028 95362600

Appendix 1: Standards of Conduct and Practice for Social Care Workers and Standards for Employers of Social Workers and Social Care Workers

Northern Ireland Social Care Council Standards of Conduct and Practice for Social Care Workers

Registrants are responsible for their own professional development and for meeting their PRTL requirements. The Northern Ireland Social Care Council Standards of Conduct **(Standard 6)** state that:

"as a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills."

This includes:

Meeting relevant standards of practice and working in a lawful, safe and effective way **(6.1).**

Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Northern Ireland Social Care Council post registration training and learning requirements in line with your job role
(6.17).

Northern Ireland Social Care Council Standards for Employers of Social Workers and Social Care Workers

Employers have a shared responsibility in supporting their staff to meet their development needs. Standard 4 of the Northern Ireland Social Care Council standards for Employers of Social Work and Social Care Workers state that:

"As a social work and social care employer, you must provide learning and development opportunities to enable registrants to strengthen and develop their skills and knowledge."

This includes:

Providing appropriate induction training and on-going learning and development opportunities to help registrants do their job effectively and prepare for any new and changing roles and responsibilities **(4.1).**

Contributing to the provision of social work and social care education and training, including effective workplace assessment and practice learning **(4.3).**

Click here to download copies of the **Standards of Conduct and Practice for Social Care Workers and Standards for Employers of Social Workers and Social Care Workers**

Appendix 2: Northern Ireland Social Care Council Continuous Learning and Development Standards

Principles of Care: The service provided by the registrant is underpinned by the quality of interaction and engagement with service users, carers and families and involves applying key values such as dignity, respect, independence, rights, choice and safety. This requires the registrant to be honest, reliable and accountable for the care they provide. The registrant must demonstrate and apply understanding of the principles of care as appropriate to his/her practice, taking account of the work context and job role. This will include adherence to the Northern Ireland Social Care Council Standards of Conduct and Practice and the values outlined in the Quality of Standards for Health and Social Care (DHSSPS 2006).

Safeguarding: The registrant must understand different forms of abuse, the signs and symptoms of abuse and have an awareness of when individuals are or might be vulnerable to abuse. Within the context of the service user group, job role and work context, the registrant should understand his/her particular responsibilities in respect of safeguarding and know how and when to act appropriately, including reporting to a senior colleague.

Communication: The registrant must know how person centred care is informed by appropriate levels and methods of communication, which can include written, verbal or other creative approaches. Within the context of his/her particular responsibilities, job role and work context, the registrant should communicate in a timely and effective way with users, carers, families and colleagues, and be able to maintain or update relevant written records to support communication.

Social Care Skills: The registrant must have skills, knowledge and understanding specific to the needs of the service user group, job role and work context. Depending on the level of responsibility and accountability for the service, direct skills and knowledge should reflect the individual registrant's specific role to provide a high quality personal care or social care service for users, carers and families.

Health and Safety: The registrant must have knowledge and understanding of the health and safety issues relevant to the context and job role and to undertake work with service users, carers and families without causing risk of injury or harm to self or others. The registrant should understand his/her particular health and safety responsibilities and, where relevant, those of other disciplines, and know how to act appropriately within the boundaries of own job role.

Compliance with mandatory health and safety training which assists organisations to meet Department of Health legislative requirements, and minimum standards against which they are regulated, is essential. This training is detailed in the Guidance for Mandatory Training in PRTL Regulated Settings (RQIA) 2010.

There are additional learning standards for senior care managers and social care managers as follows:

SENIOR CARE WORKER

Supervision and Appraisal:

Senior care workers must undertake training in respect of supervision and appraisal. Senior care workers should know how to apply skills, knowledge and understanding in their support, supervision and appraisal of staff, and be aware of the contribution this has to promote and support safe and effective social care practice.

SOCIAL CARE MANAGER

Leadership and Management:

Social care managers must undertake appropriate leadership and management skills training that addresses governance, accountability and performance management responsibilities. Social care managers should know how to apply knowledge, skills and understanding appropriate to their specific management role and be aware of the contribution this has to promote and support best practice and confidence in the quality of service provided by their organisation.

Appendix 3:

PRTL Audit Submission Form

Social Care Worker/Senior Care Worker

PRTL Audit Submission Form

Social Care Worker/ Senior Care Worker

Full name ……

Registration number……..

Employer name……..
(if in employment)

Complete electronically if possible and return via email to: registration@niscc.hscni.net

If completed manually, please return to the address below:
Northern Ireland Social Care Council
7th Floor, Millennium House
19-25 Great Victoria Street
Belfast
BT2 7AQ

Northern Ireland Social Care Council

PRTL Audit Submission Form
Social Care Worker/ Senior Care Worker

Full name ……

Registration number ……

Employer name (if in employment) ……...

Description of your Social Care Role:

_____

_____

_____

_____

Date	Duration (Hours)	Brief Description of activity	How has this activity improved your work and helped the people you Support/care for?

Date	Duration (Hours)	Brief Description of activity	How has this activity improved your work and helped the people you Support/care for?

Date	Duration (Hours)	Brief Description of activity	How has this activity improved your work and helped the people you Support/care for?

Total training and learning for period of registration (Hours): _____

Registrant Declaration

I confirm that I have undertaken the activities recorded on this form and that the details I have provided are accurate. I understand that failure to meet Post Registration Training and Learning Requirements, or the provision of false information in relation to meeting these requirements, may be considered by the Northern Ireland Social Care Council as misconduct.

Registrant Signature: _____ Date: _____

Manager's Signature: _____ Date: _____

Appendix 4:

PRTL Audit Submission Form

Social Care Manager

Audit Submission Form
Social Care Manager

Full name …….

Registration number……..……..……..

Employer name ……..
(if in employment)

Complete electronically if possible and return via email to: registration@niscc.hscni.net

If completed manually, please return to the address below:
Northern Ireland Social Care Council
7th Floor, Millennium House
19-25 Great Victoria Street
Belfast
BT2 7AQ

Northern Ireland Social Care Council

PRTL Submission Form

Summary of Social Care Role

Full Name ……

Registration number ……..

Employer name (if in employment) ……...

Summary of Social Care Role (Maximum 500 words)

Total words:

Northern Ireland Social Care Council

Northern Ireland Social Care Council

PRTL – Learning and Development Pro-forma

Name ……

Registration Number ……

Identified training Development needs	Plan to address training needs	How will this help the Registrant in their Job	Achievement Timescale

Registrant Signed…… Date:……

Line Manager/Mentor Signed:…… Date:……..

Northern Ireland Social Care Council

PRTL – Summary of PRTL Activities

Name ……

Registration Number ……

Date	Duration (Hours)	Brief description of activity

Northern Ireland Social Care Council

PRTL – Personal Statement

Name ……

Registration Number ……..……..…

Please complete the statement outline how you have met the Leadership and Management Standards:

Personal Statement (500 1500 words)

Northern Ireland Social Care Council

Total Word Count: ..... **Total training and learning for period of registration** (hours): .....

Registrant Declaration

I confirm that I have undertaken the activities recorded on this form and that the details I have provided are accurate. I understand that failure to meet Post Registration Training and Learning Requirements, in accordance with Continuous Learning and Development Standards, or the provision of false information in relation to meeting these requirements, may be considered by the Northern Ireland Social Care Council as misconduct.

Registrant Signature ..... **Date**: ……..

Line Manager/Mentor Signature ..... **Date**: ……..

Appendix 5

Examples of PRTL activities

Work based learning:

- Discussions with colleagues
- Secondment to another team/department
- Mentoring and coaching from others
- In house training related to job role
- Mandatory in house training e.g. on health and safety, equality etc
- Work shadowing
- Learning from colleagues at team meetings/case discussions
- Journal club
- Project work
- Evidence from learning activities undertaken as part of progression on the NHS Knowledge and Skills Framework

Professional activities:

- Involvement in a professional body
- Member of a special interest group
- Organising journal clubs or other specialist group
- Giving presentations at conferences
- Mentoring
- Supervising research
- Writing articles or papers

Formal Learning:

- Attending seminars/conferences
- Attending formal training programmes
- Distance learning

Self-directed learning:

- Work related reading and research (books, journals, newspapers)
- Internet research
- Social Care Council Learning Zone

Produced by:

Northern Ireland Social Care Council
7th Floor, Millennium House
19-25 Great Victoria Street
Belfast, BT2 7AQ

Tel : **028 9536 2600**
Web : **www.niscc.info**
Email : **registration@niscc.hscni.net**

First printed March 2012
Last updated September 2020

Northern Ireland Social Care Council

General Guidance for Social Work Registrants

Post Registration Training and Learning (PRTL)

October 2020
(Version 5)

Contents

PART 1: Introduction

Social workers' Post Registration Training and Learning (PRTL) is a priority for the Social Care Council to ensure the provision of quality social work services for the public. PRTL provides benefits for registrants and employers, strengthens skills within the profession and enhances public confidence in social work.

This Guidance is intended to support all social work registrants to understand the importance of Post Registration Training and Learning (PRTL). It is important that at the point of registration renewal **every** social work registrant is able to provide the Social Care Council with appropriate information about the training and learning they completed in the preceding three years of their registration. The guidance is applicable to all registered social workers including:

(a) Registrants who have recently completed the Assessed Year in Employment (AYE)

(b) Social Work Managers

(c) Registrants who are self-employed or not in employment.

What is Post Registration Training and Learning – PRTL?

The Social Care Council adopts the International Federation of Social Work (IFSW, 2014) definition of social work which states that it is "a practice based profession and an academic discipline." The Northern Ireland Social Care Council's Standards of Conduct and Practice for Social Workers require social workers to maintain an up-to-date knowledge and evidence base for their practice**.**

- Standard of Practice 2: Maintain an up-to-date knowledge and evidence base for social work.
- Standard of Practice 2: Develop social work practice through supervision, consultation, reflection and analysis.
- Standard of Practice 8: Develop yourselves and others.

Throughout your career as a social worker you must maintain and expand your knowledge in a process of continuous professional development (CPD) so that your practice is informed and based on the most up-to-date research and knowledge. The Social Care Council sets a standard of completing at least 90 hours of training and learning (PRTL) within your registration period i.e. every 3 years, to evidence your continuous professional development. This is a condition which must be met in order for your name to remain on the Social Care Council Register at your renewal of registration. (See Appendix 1 – Registration Rules –PRTL)

The Social Care Council defines Post Registration, Training and Learning as the learning and development activities through which you must maintain and develop your competence throughout your professional career and that helps you to:

- Improve the service you provide
- Develop and improve your job skills, knowledge, behaviour and practice
- Keep up to date with new practice developments, legislation and policy.

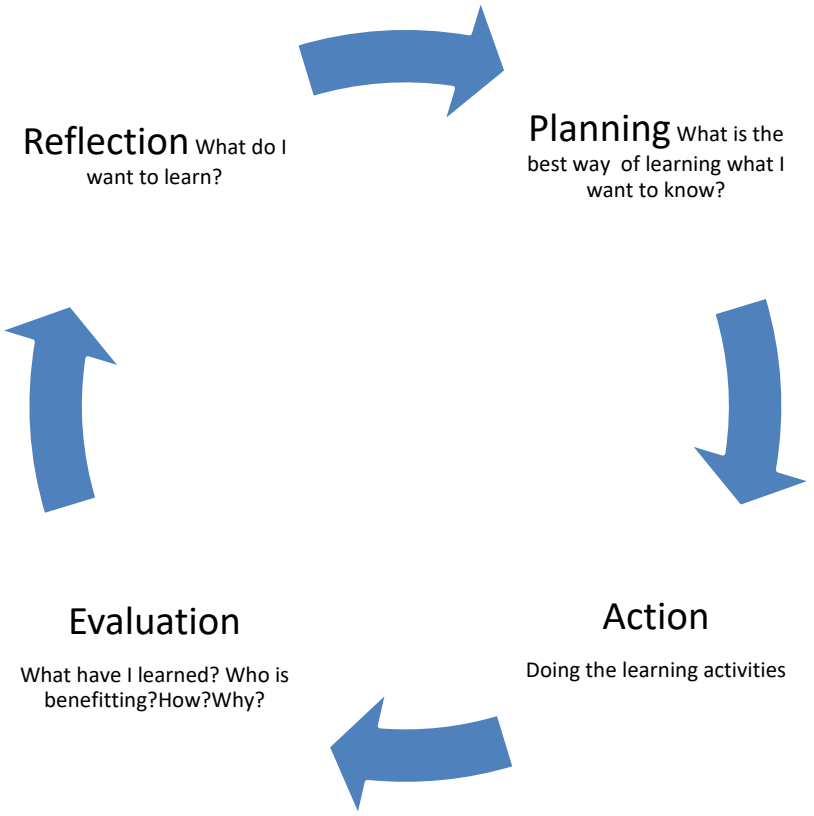
PRTL and Renewal

The Social Care Council Registration Rules require registered social workers, when they are renewing their registration (every 3 years), to provide satisfactory evidence that they have completed the required post registration training and learning. The Social Care Council will ask you to sign a personal declaration that you have met the PRTL requirements; **PRTL is a mandatory element of renewal and failure to meet this requirement may call into question your Fitness to Practise.**

The Learning Cycle

Learning and development should be a cyclical process starting with identification of learning needs. It should include reflection on those learning needs and planning activities that will meet the identified needs and contribute to improved practice (see Table 1 below).

Table 1 – The Learning Cycle



Personal Development Plan (PDP)

All registrants should have a personal development plan that incorporates the areas outlined above. (See Appendix 2 for an example).

Evidencing your PRTL

See Appendix 4 for suggested ways that you might achieve PRTL and evidence your learning.

Recording your PRTL

It is important to keep an up-to-date record of your training and learning as the Social Care Council undertakes a bi-annual audit of PRTL. Social workers can record in two different ways:

1. Via the **PRTL** facility on the Registration Portal https://portal.niscc.org/

2. Via the **Professional in Practice (PiP) (Credit Accumulation Route)** on the Registration Portal. https://portal.niscc.org/

Social Workers **are strongly encouraged** to use the **Professional in Practice Framework** which enables them to gain Professional in Practice credits whilst also meeting the PRTL requirements.

NB: Please note if social workers record their training and learning via PRTL on the Registration Portal they **will not** be able to claim Professional in Practice credits for this learning.

If you choose to record via the Professional in Practice route, contact your organisation's PiP Representative for guidance.

Click **here** for more information about **Professional in Practice**.

Responsibilities of Social Work Registrants

Registrants are responsible for their own professional development and for meeting their PRTL requirements. **The Northern Ireland Social Care Council Standards of Conduct and Practice for Social Workers**, 2019 (Standard of Conduct 6) states that:

"As a social worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills".

This includes:

"Undertaking relevant training and learning to maintain and improve your knowledge and skills and meeting the Social Care Council's Post Registration, Training and Learning Requirements in line with your job role (6.17)"

Newly Appointed First Line Managers

First line managers are recognised as occupying a particularly critical position at the forefront of service delivery, and are often charged with making the critical decisions which will determine the safety and quality of care provided to those who use health and social care services.

Evidence would suggest however that social workers often take up first line management positions without the managerial skills required or the appropriate learning and development opportunities to enable effective performance in the role.

The PRTL requirements state that social workers who are appointed as first line managers should undertake learning and development activity in the professional supervision and appraisal of staff within two years of appointment to post. This learning and development activity may include:

- Undertaking a formal programme of learning, e.g. the regional Professional Supervision Programme
- Undertaking relevant in-house training
- Making a submission through the PiP Individual Assessment Route
- Receiving formal and sustained 'on the job' coaching and mentoring support
- Participating in action learning sets within your organisation

The activity, irrespective of mode of delivery, must focus on the key tasks of professional supervision and staff appraisal and be aligned to the particular requirements of the registrant's post. It must also form a significant part of the registrant's 90 hours/15 days PRTL requirement.

The learning and development activity must also take account of any regional or organisational policies and procedures related to supervision and appraisal.

Experienced Managers

Strong professional leadership and management are required at all levels within health and social care organisations to ensure improved standards in services and better protection for service users.

While the focus for newly appointed first line managers is on professional supervision, more experienced managers will need to develop more generic managerial competences in areas such as social care governance, performance management, service improvement, project management.

Within the PRTL requirements, more experienced first line managers (i.e. more than two years in post) or other grades above this, (i.e. middle or senior managers) are required within the period of registration, to undertake learning and development opportunities appropriate to their post. These development activities should include professional leadership and management.

This learning and development activity may include:

- Undertaking a formal programme of learning, agreed by your employing organisation
- Undertaking relevant in-house training
- Making a submission through the PiP Individual Assessment Route, including having prior learning accredited (APL)

Responsibilities of Employers of Registered Social Workers

As employers you have a shared responsibility in supporting your staff to meet their development needs. The Social Care Council Standards of Conduct and Practice for Employers of Social Workers and Social Care Workers (Standard 4) states that:

"As a social work and social care employer you must provide training and development opportunities to enable registrants to strengthen and develop their skills and knowledge".

This includes:

- Providing appropriate induction training and on-going learning and development opportunities to help registrants do their jobs effectively and prepare for new and changing roles and responsibilities; (Standard 4.1).
- Supporting registrants to meet the Social Care Council's eligibility criteria for registration and its requirement for post registration training and learning. (Standard 4.4).

Staff Supervision and Appraisal

The Social Care Council Standards of Conduct and Practice for Employers of Social Workers and Social Care Workers also sets out employer responsibilities for managing and supervising staff. This includes:

- Providing appropriate supervision and support to registrants, ensuring they provide safe, effective and values-led care (3.3.)
- Ensuring and enabling registrants to have the appropriate knowledge, skills and experience to safely and effectively undertake any tasks that you delegate to them. (3.4.)
- Have appropriate systems in place to address and manager poor performance. (3.5.)

Given the emphasis on personal declaration of PRTL, there is an added responsibility on employers to ensure that their staff are undertaking appropriate development activities. The Social Care Council expects employers to have policies on supervision and appraisal that ensure adequate supervision takes place, that discussion of staff development and learning needs are integral to the supervision process and that they are reviewed at annual appraisals.

Responsibilities of Registered Social Workers who do not have an Employer

Registered Social Workers who do not have an employer, for example registrants who are:

- Self-employed
- Not in employment but wish to maintain their registration.

These registrants are subject to the same PRTL requirements as social workers in employment outlined within this Guidance.

Social work registrants who do not have an employer need to put in place alternative arrangements for the services that the Social Care Council would normally expect an employer to provide. These include:

- The development and review of a personal development plan (PDP)
- Supervision/ mentoring and support
- Training and development activities

Development of a PDP if you are self-employed or not in employment

A PDP is a tool for planning and recording learning and development needs are met. Registrants who are self-employed or not in employment may not have a PDP and may also be unsure about the direction of their career in the future. It is, however, a responsibility of all registered social workers to ensure their knowledge and skills are continuously up to date in order to ensure safe and competent practice.

A PDP should suit the purposes of the individual registrant and there are many different templates for PDPs. As a minimum it should include identified training needs, how these needs may be met and how the plan will be reviewed. The following are some triggers to help with this:

- List current knowledge and abilities and identify any gaps.
- Identify areas of expertise/ special interest and how can these be further developed
- Identify personal development which relates to a business plan (if appropriate)

A PDP should not be a static document but should be continually reviewed and amended. It is important to take time to reflect on current work, learning and plans for the future.

Registrants in employment will normally discuss their PDP and reflect on their learning with their line manager. For registrants who are self-employed or not currently in employment they will also need to find time for similar reflection and, if possible, make an arrangement with a colleague to provide them with mentoring and support.

Supervision and support

The SCC Code of Practice for Employers places a responsibility on employers to support and supervise their staff and it is expected that line managers will assist registrants to identify their learning needs and opportunities for development. Registrants who are self-employed or not in employment, will have to make their own arrangements for support and supervision/mentoring.

It is considered good practice for self-employed registrants to identify a mentor who will support and challenge their practice. This may be a manager with whom they are working under contract or a professional colleague.

For those who are unemployed the issues will be different. These registrants may need advice on the job application process or on developing new skills. A professional association may be able to help.

Training and development activities

Registrants who are self-employed or not in employment will, generally, not have access to employer supported training and will have to find other ways of meeting their PRTL requirements; there is a wide range of opportunities available. Please refer to section Appendix 4 'learning activities' for some helpful ideas.
Self-employed and unemployed registrants will not have a line manager to prompt recording of development activities. It is important, therefore, to set up a system that will support registrants to maintain a continuous, up-to-date, accurate and legible record of PRTL activities.

Voluntary Removal from the Register

Unemployed Registrants who are Unable to Meet PRTL Requirements
Unemployed registrants must consider whether they will be able to meet the requirements for post registration training and learning and whether a period of temporary voluntary removal from the register may be necessary. Registrants wishing to voluntarily remove themselves from the Register should contact the registration team for guidance at registration@niscc.hscni.net

If you remove yourself from the Register this means you are not subject to the 90 hour PRTL requirements.

You will to need to reapply to rejoin the Register prior to taking up future social work posts.

Click **here** for more information on registration.

PART 2: PRTL Standards

Post Registration Training and Learning for social work registrants is based on personal declaration. This means at your registration renewal point (every 3 years) you must declare that you have completed the required 90 hours of training and learning.

In order to meet the Social Care Council Standards for social work registrants you must:

1. Identify development needs with your manager, collate a personal development plan (PDP), evaluate your learning and maintain a continuous, up-to-date, accurate and legible record of your PRTL activities.
2. Meet the PRTL requirements for your work role as specified in Social Care Council Registration Rules (see Appendix 1).
3. Demonstrate that your PRTL activities are relevant to current or future practice which includes benefitting the service user.
4. Present written evidence that you have met these standards as required.

This means that each registrant should, in discussion with their line manager or mentor where appropriate, think about their work role now and in the future, draw up a PDP which identifies their learning needs and the activities which will contribute to furthering their development as a social worker. This plan should be reviewed at least annually. There is an example of a PDP at Appendix 2.

It is likely that your PRTL will encompass a wide range of activities from formal training to learning from others, reading journal articles etc. For each activity you need to think about how the application of your learning will improve the service you provide and benefit service users.

Deferral Due to Exceptional Circumstances

It is important that any social worker who is practising social work keeps their knowledge and skills up to date. It is appreciated, however, that there may be exceptional circumstances which are beyond your control which prevent you from completing your PRTL as required. The Social Care Council is prepared to consider requests for deferral of PRTL due to exceptional circumstances and in accordance with the Social Care Council Rules of April 2018, as set out below:

> *Rule 8 (9) The Council shall not refer a registrant to the Registration Committee in accordance with Paragraph (7)) where that registrant has failed to complete the post registration training and learning requirements due to exceptional circumstances or where the registrant is on maternity, adoption or fostering leave.*

If you think you will be unable to complete your PRTL due to exceptional circumstances you should outline the reason via email to the Social Care Council registration team at registration@niscc.hscni.net **at least 20** days before your renewal is due.

PART 3: PRTL Audit

The Audit Process

At two points in the year the Social Care Council will select a random sample of registrants to provide a submission containing information on how they have met the PRTL Standards. The submission will be assessed against the criteria as outlined in Table 2: **Standards and Assessment Criteria for PRTL Audit** (See page 14).

Any registrants who have previously deferred an audit or have had relevant PRTL conditions placed on their registration will automatically be included in the audit.

Exemption from audit

The following are the ways you can be exempt from audit:

- If you have accumulated 100 credits via the Professional in Practice (PiP) Credit Accumulation Route (this equates to one PiP requirement) within the audit period.
- If you have achieved one PiP requirement by any other route within the audit period.

PRTL submission for audit

If you have been selected for audit you will be informed five months in advance of the date you are required to submit your PRTL submission to the Social Care Council. PRTL submission dates will be **1st June** and **1st December** each year. You will be advised which of these dates you must meet. If you fail to submit within the required timescale, unless there are exceptional circumstances (see page 11), it may be considered impaired Fitness to Practise. *Rule 8 (7) Northern Ireland Social Care Council (Registration) Rules 2017.*

If you have submitted evidence of partially meeting the standards you will be given one opportunity to resubmit.

Your audit submission should include the following:

- Summary of your social work role (maximum 500 words). This should describe your current role and the type of work you do. The summary should include a brief description of your main responsibilities.
- Personal Development Plan (PDP). This should identify your learning and development needs and the activities you planned to undertake to meet these needs.(Appendix Two)
- Summary of PRTL activities undertaken. Give a brief description of each activity included.
- Personal statement - maximum 1500 words. This should demonstrate evidence of reflection and evaluation of your development and should describe how you meet Standards of Practice 3 and 4; For example, you should explain what you did, what you learnt, what you would do differently as a result and who has benefitted.

There is further information on compiling your submission in Part 4 of this Guidance.

Renewal of Registration

To prevent delays to the renewal of registration process, those registrants who are selected for PRTL audit should complete their registration renewal form in the usual way and submit it to the Social Care Council within the required timescale – separate from their PRTL submission.

TABLE 2 Standards and Assessment Criteria for PRTL Audit

Standard	Standard met	Standard partly met	Standard not met	Evidence
1. A registrant must Identify development needs, collate a PDP, evaluate their learning and maintain a continuous, up-to-date, accurate and legible record of their PRTL activities.	The registrant has submitted a PDP and a summary of their PRTL activities. There is evidence of evaluation of learning.	PDP not submitted but acceptable explanation given, Or A record of activities has been submitted but learning has not been evaluated, Or Records are not legible	The registrant has not provided any evidence that they have met the Standard	PDP Record of PRTL activities Personal statement demonstrating evaluation of learning activities
2. A registrant must meet the PRTL requirements for their work role as specified in SCC Registration Rules (see Appendix 1)	Records have been submitted which demonstrate the PRTL requirements have been met	Requirements have been partially met	No evidence has been submitted to demonstrate the requirement has been met.	Summary of work role Evidence of PRTL appropriate to work role
3. A registrant must demonstrate that their PRTL activities are relevant to current or future practice	The registrant's personal statement demonstrates that their PRTL activities are relevant to current or future practice	The personal statement provides some but insufficient evidence that the PRTL activities are relevant to current or future practice	The registrant has not provided a personal statement and summary of work role, Or Has not demonstrated that their PRTL is relevant to current or future practice.	Summary of work role Personal statement

Standard	Standard met	Standard partly met	Standard not met	Evidence
4. A registrant must seek to ensure that their PRTL has contributed to improving the quality of their practice and service delivery including benefitting the service user; or explain why this has not been achieved and outline plans for how this can be met in future	The registrant's personal statement demonstrates reflection on their learning and describes how their practice has improved and how this has contributed to better outcomes for service users. If their learning has not had the desired effect an explanation is given and plans outlined for how future PRTL activities will benefit service users.	There is some but insufficient evidence that the registrant's PRTL activities have improved the quality of their work and benefitted service users	There is no evidence that the registrant's PRTL activities have improved the quality of their work, Or Benefits to service user have not been explained	Personal statement
5. Upon request, present written evidence that they have met these standards.	Full documentation has been provided within the required timescale	Documentation has been provided but is incomplete	The registrant did not return their PRTL documentation by the deadline	Documentation as listed above returned by deadline

Assessment

The Social Care Council's PRTL assessors will assess your PRTL submission against the criteria in the table above. These PRTL assessors are qualified social workers who have been trained to assess PRTL submissions. If you partially meet a Standard the Social Care Council will write to you giving brief feedback on your submission and request further information to be submitted within 20 days. If your submission still fails to meet all PRTL Standards this may call into question your Fitness to Practise.

PART 4: Compiling your PRTL Submission

If you are chosen for audit the Social Care Council will send you a PRTL submission form to complete (there is a sample form at Appendix 3)

Your submission must include:

1. **A summary of your social work role (up to 500 words).**

   This will help us to assess if the activities you have undertaken are appropriate to your work role. You should describe your main responsibilities and the service users with whom you work, other professionals, students and learners. Your main responsibilities may be written in bullet point format but there should be some narrative about your workrole.

2. **A Personal Development Plan (PDP)**

   For social workers in employment this should be agreed between you and your line manager and regularly reviewed.

   Social workers who work independently should also review their development needs and plan how to meet them. It is good practice to discuss this with a colleague or mentor.

   A sample plan is included at Appendix 2
   The plan should be signed and dated.

3. **A summary of PRTL activities undertaken**

   The PRTL Submission Form (Appendix 3) asks registrants to list the activities undertaken and the hours spent on each activity.

   Many of the activities undertaken will link to learning needs identified in the training and development plan but others will be unplanned opportunities that contribute to developing your knowledge and skills.

   It is expected that social workers' PRTL will include a range of activities, for examples of this see Appendix 4.

4. **A statement saying how you have met our PRTLStandards**

   Your personal statement should demonstrate reflection on and evaluation of your learning. You should concentrate on how you meet the PRTL Standards 3 and 4 (Table 1), that is, how your PRTL activities have improved the quality of your work and the benefits to service users.

Appendix 1: - Northern Ireland Social Care Council (Registration) Rules, 2017

Rule 8(6)(c) – Schedule 3: Post registration training and learning requirements

1 Social workers and social care workers

(1) All social workers and social care workers, within the period of registration, complete a minimum of 90 hours of learning and development activity which may include study, training, courses, seminars, reading, teaching or other activities which could reasonably be expected to advance the social worker's professional development, or contribute to the development of the profession as a whole.

2 Social workers

(1) The following requirements apply to social workers in the following categories. The training specified will contribute to the 90 hours of learning and development activity in paragraph 1(1) above.

(a) Social workers in the first three year period of registration following successful completion of the Assessed Year in Employment shall complete a minimum of two requirements of the Northern Ireland Consolidation Award within the period of registration.

(b) Social workers who are appointed as first line managers shall undertake learning and development activity in the professional supervision and appraisal of staff within two years of appointment to post.

(c) Social workers who are first line managers or managers in other grades above this shall undertake, within the period of registration, learning and development activities appropriate to their post. These development activities should include professional leadership and management.

3 Every social worker and social care worker registered with the Council shall keep a record of post registration training and learning undertaken.

4 Failure to meet the foregoing post registration training and learning requirements may be considered misconduct by the Council.

5 In the case of a social worker registered in the visiting European part of the Register, where the social worker is required to undertake post registration training and learning, the social worker shall complete 5 days (30 hours) each year, of study, training courses, seminars, reading, teaching or other activities which could reasonably be expected to advance the social worker's professional development, or contribute to the development of the profession as a whole

Appendix 2: Example of a Personal Development Plan

Identified training (development) needs	Plan to address training needs	How will this help the Registrant in their job?	Achievement timescale

Signed: ..... Registrant

Registration Number: .....

..... Line Manager/Mentor (ifavailable)

Appendix 3: PRTL Submission Form

Full name: .....

Employer name (if in employment): .....

Registration Number: .....

Total word count:.....
Summary of Work Role (maximum 500 words): .....
.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

PRTL Submission Appendix 3 (continued)

Personal Statement (Maximum 1500 words) Page 1:

This should demonstrate that you have evaluated your learning and describe how you met standards 3 and 4 (Additional space is provided on pages 21 and 22).

Total word count:.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

PRTL Submission

Appendix 3 (continued)

Personal Statement (Maximum 1500 words) Page 2:

PRTL Submission Appendix 3 continued)

Personal Statement (Maximum 1500 words) Page 3:

PRTL Submission
Summary of PRTL Activities

Appendix 3 (continued)

Date	Duration (hours)	Brief description of activity

Total training and learning for period of registration in Hours _____

Registrant Declaration
I confirm that I have undertaken the activities recorded on this form and that the details I have provided are accurate. I understand that failure to meet Post Registration Training and Learning Requirements, or the provision of false information in relation to meeting these requirements, may be considered by the Northern Ireland Social Care Council, as misconduct.

Signed ..... Registrant

Registration Number .....

Appendix 4: Examples of PRTL activities

Formal learning

- Attending seminars/conferences
- Attending formal training programmes e.g. PiP Approved Programmes
- Distance learning

Professional activities

- Involvement in a professional body
- Member of a special interest group
- Organising journal clubs or other specialist group
- Giving presentations at conferences
- Mentoring
- Supervising research
- Writing articles or papers

Professional in Practice

- Achievement within the Individual Assessment Route
- Achievement within the Approved Programme Route
- Achievement within the Credit Accumulation Route
- Achievement within the Work-based Learning Route

Self-directed learning

- Work- related reading and research (books, journals, newspapers, television programmes)
- Internet research
- Social Care Council Learning Zone

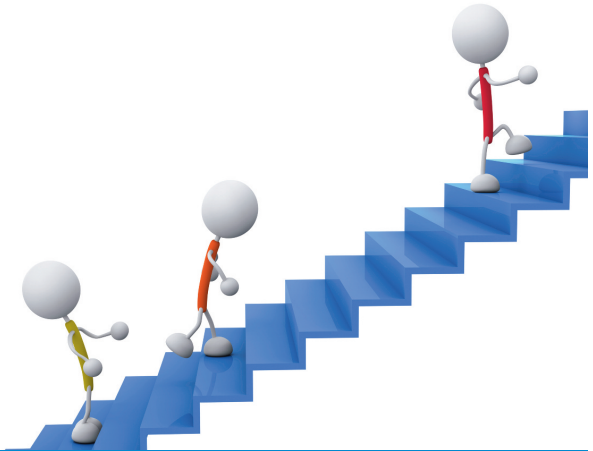
Work-based learning

- Discussions with colleagues
- Secondment to another team/department
- Mentoring and coaching from others
- In-house training related to job role
- Mandatory in-house training
- Work shadowing
- Learning from colleagues at team meetings/case discussions
- Journal club
- Project work
- Evidence from learning activities undertaken as part of progression on the NHS Knowledge and Skills Framework

For further information about Post Registration Training and Learning Requirements for Registered Social Workers

Contact:
Northern Ireland Social Care Council 7th Floor Millennium House
19-25 Great Victoria Street Belfast
BT2 7AQ

Tel: 028 95 363600
Email: registeration@niscc.hscni.net
Web: www.niscc.info



BASW Continuing Professional Development (CPD) Policy

BASW
THE BRITISH ASSOCIATION OF SOCIAL WORKERS

Date: February 2012

Author: The Policy, Ethics and Human Rights Committee

Contact: Fran McDonnell, Policy Team

Email: policy@basw.co.uk

BASW Continuing Professional Development Policy

BASW CPD Policy **Purpose**

Purpose

The purpose of this policy is to clarify what BASW considers to be the professional rights and responsibilities of social workers in relation to Continuing Professional Development (CPD) and the essential role that BASW has in supporting members with their development. CPD is vital to ensure that social workers provide quality services, develop their practice and achieve good outcomes for individuals, families and communities.

It is intended that the CPD policy and definition should apply to all UK countries and social workers, whilst recognising that the context and requirements for re-registration are different in each country (A description of the context for each country is in the Appendix.). The policy is primarily for social workers but is also important for employers and education and training providers. It covers the broad responsibilities of employers and supervisors in supporting CPD for social workers.

Social workers are members of an internationally recognised profession, a title protected in UK law. The International Federation of Social Workers (IFSW) has developed a Charter of Rights for social workers. Two of the rights are access to opportunities for lifelong learning and "career progression routes, which maintain practice[1]."

Social workers demonstrate professional commitment by taking responsibility for their conduct, practice and learning, with support through supervision. By doing this, social workers empower themselves as professionals to progress and achieve their aims and goals, whether they are working within an organisation or independently.[2] Social workers should continually develop the knowledge, skills and values required for their own role and their professional and career development. They need to proactively manage their own training and development needs as an integral part of their job.[3]

Employers have a responsibility to actively provide learning opportunities to meet the professional development needs of social workers and to ensure they meet CPD requirements. These requirements may be defined in codes of practice, codes of ethics, regulatory requirements, professional practice standards, practice governance frameworks, professional capabilities frameworks, career structures and CPD frameworks, which contextualise social work practice in each country.

CPD benefits employers as it provides better outcomes for people who use services and improves recruitment and retention. Engaging in learning and development, linked to organisational and individual priorities and objectives, supports service improvement. Employers should ensure there are planned and strategic approaches to learning and development, within a learning culture which is open and fair.[4]

Definition of CPD

Continuing Professional Development is an on-going, planned learning and development process, which improves practice, contributes to lifelong learning and enables career progression.[5] CPD is the process 'through which professionals maintain and develop their knowledge and skills throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice'.[6]

CPD encompasses all learning as a social worker and values the whole spectrum of learning activities, including professional supervision, peer group learning, placements, training programmes and higher level qualifications. This enables flexibility and choice about how to meet individual learning needs. CPD incorporates the requirements for, but is more than, re-registration as a social worker in each country.

Reflection is a central aspect of on-going learning and development. IFSW states that social workers have a right to work "critically, effectively and reflectively"[7]. Munro[8] describes reflection as the learning to be gained by engaging in deliberate practice, built on reviewing prior experience to derive new insights and lessons, and on feedback that is accurate, diagnostic and timely. Reflective practice requires time. Professional development is more effective if undertaken within a learning culture and evaluated in terms of outcomes for the social worker and people who use social work services.

BASW CPD Policy **Definition**

CPD should enable and support social workers to:

- develop professional capacity, professional identity and confidence over the course of their careers
- make sound professional judgements, decisions and interventions based on evidence-informed practice
- update, extend and deepen knowledge, skills and analytical thinking to deal with increasingly complex and specialist work
- keep up to date with relevant research, learning from other professionals and service users[9]
- work to the BASW Code of Ethics[10] and support the rights of service users
- take responsibility for own personal growth and developing others
- value learning and widen the definition of what counts as useful activity
- reflect on learning in terms of outcomes for professional development and outcomes for service users
- use reflective practice to engage with new knowledge and skills so learning is always linked to action, and theory to practice
- understand how individuals learn best and have a personal development plan that reflects this
- meet re-registration requirements
- plan their careers and remain in the workforce.

BASW CPD Policy **Statement**

Policy Statement

1. The provision of regular, planned CPD is central to the development and maintenance of high quality social work and to developing professional identity and confidence.
2. Social workers should be able to work in an environment which values and gives a high priority to continuing learning and development.
3. Social workers should have regular appraisal and updated personal development plans that identify learning based on an analysis of each social worker's individual needs and personal learning style.
4. Social workers should have space for critical reflection and learning from others through professional supervision, peer learning, professional networks and involving people who use services.[11]
5. Social workers should have access to on-going, planned learning opportunities to maintain and develop knowledge and skills for current roles, progress career development and enable re-registration. This should include, as appropriate, opportunities to access training and higher education awards, recognising that different learning activities may lead to different outcomes.
6. Social workers should have access to CPD systems and processes which support learning and career development and focus on improved outcomes for children, adults, families and communities.
7. Social workers should have opportunities at all levels to contribute to the continuous improvement of practice, engage in research and evidence informed practice. The impact of learning on practice should be evaluated systematically and used to inform planning.
8. Employers should regard CPD as an entitlement, a responsibility and a necessity, in order to maintain and improve practice and service delivery now and in the future, and to support the next generation of social workers. Employers should have a strategy for learning and development based on the learning needs of social workers, workforce planning needs of the organisation and local and national priorities.
9. Social workers should be able to access information and support for CPD through BASW as a professional body. This will include access to a knowledge hub, recording CPD linked to each country's systems for registration and opportunities for sharing expertise and knowledge.
10. Social workers, with the support of the professional body, should expect to work with employers, regulators and training providers to develop an approach to CPD which improves the effectiveness, quality and relevance of learning and practice.

Appendix: Context for CPD in the UK (January 2012)

England

Over the last few years the government has supported substantial work to develop and promote CPD. This includes the development of the GSCC PQ framework and the joint 'Framework for CPD' developed and published by Skills for Care (SfC) and the Children's Workforce Development Council (CWDC) (2008). However, in practice CPD has been seen only as achieving higher education post-qualifying awards or meeting post registration training and learning requirements (PRTL) based on inputs or number of hours engaged in learning activity. Social workers themselves and employers have found it hard to find the time or resources to engage in CPD.

The Social Work Task Force report 'Building a Safe and Confident Future' (2009)[12] recommended the development of a more coherent and effective national framework for the continuing professional development of social workers. They stated that such a framework should be accompanied by mechanisms to encourage a shift in culture which raises expectations of an entitlement to on-going learning and development.

The Social Work Reform Board (SWRB) published "Proposals for implementing a coherent and effective national framework for the continuing professional development of social workers" on 26th May 2011. The CPD framework acknowledges that professional development and learning is more effective if undertaken as part of reflective practice and evaluated in terms of outcomes for the professional and for service users.

The new **CPD framework**[13] is more flexible and recognises the value of all learning opportunities to professional development, including informal and self-directed learning. The framework will be aligned with the relevant levels of **the Professional Capabilities framework (PCF)**[14] and linked to career structure.

The SWRB said that social workers should be supported by employers and expected to take professional responsibility for developing their skills to a high professional level. Alongside the CPD framework, the Reform Board has also developed the **Standards for Employers and Supervision Framework**, which clearly set out the duty of employers to support CPD for social workers through supervision and protected time to undertake learning and development.[15]

There is recognition throughout all the frameworks that social workers do not work or learn in isolation, but are responsible to managers and for themselves and other colleagues, who may be social workers or come from different professional backgrounds. As professionals, they also have a duty to educate less experienced colleagues and prepare them to become the next generation of social workers.

From 2012, the registration of social workers in England will become the responsibility of the Health Professionals Council (HPC). Social workers will have to meet **Standards of Continuing Professional Development**[16] for re-registration, instead of PRTL. Social workers will be expected to take personal responsibility for self-directed learning and development, and to record the range and outcomes of their learning activity. These developments provide an opportunity to develop CPD that is driven by the profession to improve the quality of the service we provide.

Northern Ireland

The Northern Ireland Social Care Council (NISCC) is the regulator for the social care workforce. As the Sector Skills Council for Social Care, Child Care and Early Years workforces in Northern Ireland, it is responsible for developing and promoting high standards in learning, training and development.

NISCC is responsible for registering the social care workforce including social workers. **The Code of Practice**[17] is the same as the other countries, as are the requirements for **Post Registration Training and Learning** (PRTL). PRTL must be related to social care work and improved outcomes for service users. The aim may be to improve performance in the current job or it could involve working towards improvement in service delivery through staff training or research.

In Northern Ireland, a social work training strategy[18] reported limited career structures and set a target of 2010 to develop career pathways linked to agreed and accredited training and/or qualifications linked to continuing registration.

The NISCC intends to introduce a **Continuous Learning Framework** from 2012[19], which will inform/guide PRTL requirements for social care registrants. This will introduce learning standards and PRTL requirements reflecting the level of responsibility of the social care registrant. PRTL activities will be flexible to include work-based learning such as supervision and discussions/learning with colleagues; other learning activities such as involvement in a professional body and research; as well as formal learning.

The framework is likely to have Core standards and Supplementary standards for senior workers and managers. Some examples of the supplementary standards for social workers are:

- Social workers in the first three year period of registration, following successful completion of the Assessed Year in Employment shall complete a minimum of two requirements of the NI Specific Award within the period of registration. This award is part of the NI social work post-qualifying award framework.
- Social workers who are appointed as first line managers shall undertake learning and development activity in the professional supervision and appraisal of staff within two years of appointment to post.

The Northern Ireland Post Qualifying Education and Training Partnership for Social Work (NIPQETP), is part of the NISCC. It aims to improve the quality of social care in Northern Ireland by supporting the practice, continuing education and performance of qualified social workers.

The **NI Post Qualifying Framework for Social Work** is an education and training framework for registered social workers wishing to develop and enhance their skills and qualifications throughout their career in the social work profession. The NI PQ Framework became operational on 1st April 2007.

The PQ Framework has a range of professional requirements that can be achieved through a modular approach to required education and training standards. Achievement of these professional requirements can lead to the three professional awards. The professional awards are made and certified by the Northern Ireland Social Care Council.

Scotland

The Scottish Social Care Council (SSCC) is responsible for registering the social care workforce including social workers. The SSCC Code of Practice requires workers to take responsibility for maintaining and improving their knowledge and skills. It is expected that training and learning will contribute to professional development and assist in meeting roles and responsibilities in an informed, competent and confident manner. These responsibilities are set out in the **Codes of Practice for Social Service Workers and Employers** of Social Service Workers.[20]

The requirements for **Post Registration Training and Learning** (PRTL) for social workers is the same as in the other UK countries, to complete a minimum of 15 days (90 hours) of study, training, courses, seminars, reading, teaching or other activities. The type of activity stated as acceptable is deliberately general because it is recognised that there are a variety of ways for registered social workers to continue to learn and develop.

In addition, the registration rules in Scotland[21] state that at least five days, or 30 hours, training and learning activity shall focus on working effectively with colleagues and other professionals to identify, assess and manage risk to vulnerable groups. This is in order to ensure that social workers are assisted to meet their primary responsibility of protecting children and adults from harm.

This requirement applies to both children and adults irrespective of the social worker's current work context. For example, it is important that a social worker working in a criminal justice team understands and is equipped to meet their responsibilities in relation to child protection and it is equally important that a social worker working in a child care team understands and is equipped to meet their responsibilities in relation to adult protection. There is no prescribed balance between child and adult protection and it is recognised that the present job role and specific responsibilities may mean that the focus may be more on the protection of children or adults. However it is essential that your evidence covers both service user groups.

The Scottish Executive has recently launched a Child Protection webspace to support workers undertaking child protection work in Scotland to assist registered social workers to meet this specific PRTL requirement.[22]

The guidance on PRTL also recognises the importance of supervision and staff development schemes to discuss professional development needs and identify and plan training and learning that will increase skills and knowledge and inform practice. It is also

recommended that at least annually in supervision or in a specific professional development meeting that PRTL should be reviewed, evaluated and recorded to ensure requirements are being met. People who are self-employed still need to satisfy the SSSC that they have completed the required 15 days PRTL including the 5 days on protecting children or adults from harm.

In addition to the SSCC guidance, the Scottish Social Services Council (SSSC) has developed a **Continuous Learning Framework**.[23] This is the key output from the workforce development change programme under 'Changing Lives'[24]. The Framework sets out what all people in the social service workforce need in order to be able to do their job well now and in the future.

The Framework is progressive and is intended to improve approaches to three key areas – learning and development, career pathways and improved standards of practice. In order to facilitate the use of the Framework in practice, tools and resources will be developed for social service workers and their employers. There are already tools available in Workforce Solutions[25].

The organisational capabilities[26] support organisations to determine how best to support their employees and to evaluate the impact of learning and development initiatives. It is recommended that organisations consider each of the organisational capabilities when looking to improve the culture and conditions in the workplace.

The Practice Governance Framework (2011)[27] clarifies the respective responsibilities of employers and practitioners in respect of CPD.

Wales

Social workers in Wales have had to register with the Care Council for Wales since 2003. The title 'Social Worker' has been protected in Wales since 1st April 2005. In order to register social workers have to sign up to **The Codes of Practice**, which set out agreed professional standards. It forms part of a wider package of legislation, practice standards and employers' policies and procedures that social care workers must meet. Part of the Code states that "social care workers must be accountable for their work and take responsibility for maintaining and improving their knowledge and skills (Code 6)[28]."

As in other UK countries, social workers are required to submit a record of **Post Registration Training and Learning** (PRTL) of 15 days or 90 hours every three years in order to re-register. Social workers should maintain a portfolio of evidence to support their PRTL record. The PRTL Requirements for Registered Social

Workers and Social Care Workers – Guidance[29] describes the key features of post-registration training and learning as:

- flexibility to allow for individual circumstances and aspirations
- shared responsibility between manager and practitioner
- allows for a range of routes with no preference
- incorporates individual training needs
- incorporates an employment-based focus.

As part of CPD, the Care Council recognises that there are many ways to continue to learn and develop as a social worker so have avoided being too specific about the type of activities that will meet requirements. The training and learning that registrants choose should:

- benefit their personal development needs
- benefit their current employment
- benefit their career progression
- reflect their preferred learning style
- make the most of the learning opportunities available to form part of their wider professional development; and
- improve their ability to provide high quality services to service users and carers.

Employers have a shared responsibility in supporting workers to meet these requirements which is stated in the Employer Code of Practice.

In November 2009 there was a discussion paper on Social Work Career Pathways, linked to post qualifying training and work based learning. There has subsequently been a consultation on a new **"Continuing Professional Education and Learning: A Framework for Social Workers in Wales"** (CPEL framework). A CPEL Implementation Group started work in November 2011 and will develop the framework.

BASW CPD Policy **References**

References

1 International Federation of Social Workers (IFSW) Charter of Rights for Social Workers 2011 http://www.ifsw.org/f38000106.html

2 Draft paper for the Social Work Reform Board (SWRB) from CPD working group 2011

3 Changing Lives practice Governance Group Practice Governance Framework responsibility and accountability in Social Work Practice (2011) Scottish Government

4 Changing Lives practice Governance Group Practice Governance Framework responsibility and accountability in Social Work Practice (2011) Scottish Government

5 Adapted from CWDC/Skills for Care Continuing Professional Development Strategy 2008

6 Health Professions Council (HPC) Guidance on CPD

7 IFSW Charter of Rights for Social Workers 2011 http://www.ifsw.org/f38000106.html

8 The Munro Review of Child Protection: A child centred system, (May 2011)

9 BASW Code of Ethics 2012

10 BASW Code of Ethics 2012

11 BASW Supervision Policy 2011

12 Building a Safe and Confident Future (2009) Social Work Taskforce

13 http://www.education.gov.uk/swrb/a0074253/framework-for-continuing-professional-development

14 The Professional Capabilities Framework http://www.collegeofsocialwork.org/uploadedFiles/TheCollege/Practice/PCF%20Explanation.pdf

15 http://www.education.gov.uk/swrb/a0074263/standards-for-employers-and-supervision-framework

16 http://www.hpc-uk.org/aboutregistration/standards/cpd/

17 http://www.niscc.info/CodeofPractice-10.aspx

18 Personal Social Services Development and Training Strategy 2006-2016, Department of Health, Social Services and Public Safety, September 2006

19 NISCC Consultation on a Continuous Learning Framework for Social Care Workers and Post Registration Training and Learning Requirements – closing date 25th October 2011

20 www.sssc.uk.com.

21 SSCC Registration Rules 2011

BASW CPD Policy **References**

http://www.sssc.uk.com/sssc/useful-information/registration-rules-and-conduct-rules.html

22 http://www.workspace.cp.scot.nhs.uk/default.asp

23 The Scottish Social Service Council/IRISS: The Framework for Continuous Learning in Social Services (2008) http://www.continuouslearningframework.com/clf/home/welcome-to-the-continuous-learning-framework-website.html

24 Scottish Executive (2006a) Changing Lives: Report of the 21st Century Social Work Review, Edinburgh: Astron

25 http://workforcesolutions.sssc.uk.com/

26 Appendix 2 http://www.continuouslearningframework.com/clf/home/welcome-to-the-continuous-learning-framework-website.html

27 Changing Lives practice Governance Group Practice Governance Framework responsibility and accountability in Social Work Practice (2011) Scottish Government

28 http://www.ccwales.org.uk/registration-and-conduct/confidence-in-care/the-codes-of-practice

29 http://www.ccwales.org.uk/registration-and-conduct/current-registrants/renew-registration-part-one

The British Association of Social Workers
16 Kent Street
Birmingham B5 6RD

Tel: 0121 622 3911 Fax: 0121 622 4860

Copies of this policy are downloadable at:
www.basw.co.uk

Capabilities Statement for

Social Workers Working with Adults with Learning Disability

Department of Health & Social Care

BASW England
The professional association for social work and social workers

Introduction

This *Capabilities Statement for Social Workers Working with Adults with Learning Disability (the Capabilities Statement)* has been commissioned by the Department of Health and Social Care (DHSC) for England and developed by the British Association of Social Workers (BASW) with input from Research in Practice for Adults (RiPfA). It is landmark guidance filling a longstanding gap in this vital field of social work.

There are over 1.5 million people with a learning disability in the UK and the number is growing. Social workers support people with lived experience of learning disabilities in all fields of practice – in children and families and adults social care services, in hospital and community contexts as well as in specialist learning disability services. Generic social work capabilities are the essential foundation to good practice and good experience for citizens. Deeper knowledge and more specialised approaches are also needed, particularly in tackling the inequalities and poor services that people with learning disabilities often experience.

Social work values, ethics and skills are key to ensuring personalised care and support, human rights-based practice and robust advocacy are available for people with lived experience of learning disabilities. Inadequate and sometimes abusive institutional services are still being experienced by people with learning disability. Confident and effective social work is essential within multidisciplinary services and commissioning to accelerate improvements in the quality of care and support. Social workers need the capabilities to ensure community-based support is planned and provided, maximising people's potential for independence and self-determination, living the lives they want. This *Capabilities Statement* supports this vital social work contribution.

This *Capabilities Statement* is accompanied by a Continuing Professional Development (CPD) pathway and supporting resources (on the BASW and DHSC websites). These provide a practical framework to promote improvement of practice and positive impact of social work in this field.

Methodology

The *Capabilities Statement* was developed between October 2018 and March 2019 through literature review, consultation and involvement of stakeholders. The work was overseen by a Stakeholder Reference Group which included people with lived experience, their family, friends and carers, social workers, managers and academics. Principles of co-production, meaningful involvement and giving equal value to most marginalised voices were central throughout.

Consultation with a wide variety of stakeholders was undertaken through:

- An online survey
- Consultation and involvement discussions with people with lived experience via existing services and service-user led groups and organisations
- Deep-dive discussions/interviews with key stakeholders

The *Capabilities Statement* is also informed by the evidence base from research and practice. A literature review that informed this work can be downloaded on the BASW website). Key references are included in this document.

Who is this practice guidance for?

The *Capabilities Statement* provides guidance for professionals, managers and other stakeholders involved in delivering social work and social care with people with lived experience of learning disability. It outlines expected practice standards for social work. It will also be useful for people with lived experience of learning disability and their families to know what to expect from social workers.

The *Capabilities Statement* is particularly aimed at supporting:

- Social workers – to explore and understand capabilities associated with good practice in generic and specialist services; to promote the human rights, ethics and values driven purpose and practice of social work in this field and to frame social work CPD priorities to improve the practice and impact of social work

- Higher Education Institutions, researchers and providers of social work training – to develop and deliver curriculum content; plan the involvement of people with lived experience in teaching and research; develop assessment criteria and identify practice learning requirements in the qualified and qualifying workforce

- Local authorities – to develop services, effective commissioning and review capabilities and to provide learning and development for all social workers. Where services are being reconfigured (e.g. from specialist to generic or vice versa this *Capabilities Statement* can shape the training that social workers require

- Managers and leaders – to inform supervision and evaluation of practice through reflecting on components of the *Capabilities Statement*, to support recruitment and retention of staff and to inspire effective practice, organisational and systems leadership for excellence

- Practice Educators and University Staff – for teaching and assessing students' capability and suitability in practice with people with lived experience of learning disability.

Although aimed primarily at practice with adults, this guidance is also applicable to children's services in a number of ways including:

- People with lived experience of learning disability may be parents and may encounter social workers in their own right, or their children may have social workers

- Young people with learning disability often require support in the transition to adulthood and there will be an overlap between children and adult services at this point

- The new Liberty Protection Safeguards, part of the Mental Capacity Act 2005, apply to people aged 16 and above, requiring social workers in children and families to have more capability in this area of law and practice.

Links with the Professional Capabilities Framework and Knowledge and Skills Statements

The *Capabilities Statement* is framed by the Professional Capabilities Framework (PCF) – www.basw.co.uk/pcf. It also supports social workers to meet the expectations of the Knowledge and Skills Statement for Social Workers in Adult Services.

> *'Together, the PCF and KSS provide the foundation for social work education and practice in England at qualifying and post-qualifying levels and are used to inform recruitment, workforce development, performance appraisal and career progression.*
>
> *The PCF guides the development of social workers' capabilities and confidence in managing risk, ambiguity and complexity at nine levels of practice across all specialisms.... The KSS set out what a social worker should know, and be able to do, in specific practice settings, in specific roles and at different levels of seniority'.*
>
> – From Joint statement on the relationship between the Professional Capabilities Framework (PCF) for Social Work and the Knowledge and Skills Statements for Children and Families and for Adults – April 2018
>
> **Read the full statement at www.basw.co.uk/sites/default/files/basw-pcf-and-kss-joint-statement.pdf**

Originating from the work of the Social Work Reform Board, the PCF outlines the generic capabilities that underpin *all* social work practice in England.

There are **nine domains** of capabilities in the PCF grouped under three overarching 'super domains' - *Purpose, Practice, Impact.* As shown in the diagram below, the Domains of the PCF are: 1. Professionalism 2. Values and Ethics 3. Diversity and Equality 4. Rights, Justice, and Economic Wellbeing 5. Knowledge 6. Critical Reflection and Analysis 7. Skills and Interventions 8. Contexts and Organisations 9. Professional Leadership.

All generic PCF domains are important for social work with people with lived experience of learning disabilities. However, the *Capabilities Statement* defines specific capabilities that enhance and deepen social work practice with adults with this lived experience.

Levels of practice and CPD

The PCF supports CPD by identifying and promoting different levels of capability from prequalifying to Advanced and Strategic levels. The PCF describes how social workers advance their practice through working with more complexity, ambiguity and autonomy. Further description of the capabilities for social work with adults who have learning disability at all levels of the PCF are contained in the accompanying online CPD resources on the BASW website.

Structure of the Capabilities Statement

The *Capabilities Statement* is structured around the PCF 'super domains' ***Purpose, Practice, and Impact***[1]. These inter-relate, but each focus on three discrete areas of professional development.

- The **Purpose** section of the *Capabilities Statement* describes the values, ethics and approach to rights and equalities that social workers need to demonstrate to make a positive impact for people with lived experience who often experience (or are at risk of) social exclusion and discrimination

- The **Practice** section describes the knowledge, skills and critical reflection capabilities specific to social work practice with people with lived experience of learning disability

- The **Impact** section shows the professionalism, organisational, leadership, and self-management skills that are needed in this area of practice.

[1] https://www.basw.co.uk/system/files/resources/PCF%20Final%20Documents%20Overview%2011%20June%202018.pdf

What was most important to people with lived experience?

The diagram above illustrates the elements of social work capability that were emphasised throughout the co-production and development of the *Capabilities Statement* with people with lived experience, their families and professional stakeholders, particularly within the Steering Group.

The three sides of the triangle and its centre (critical reflection) are inter-dependent. Each dimension needs to be achieved simultaneously in practice to make the most positive difference for adults who have a learning disability.

The *Capabilities Statement* Stakeholder Reference Group emphasised the importance of Positive *Values, Ethics and Personal Behaviours,* placing this at the bottom of the triangle as the foundation of good social work. This means social workers building and sustaining positive relationships, taking time to:

- **get to know people with lived experience as individuals**
- **listen and know how to communicate effectively**
- **support their family and friends**
- **help them lead the lives they choose**
- **show respect and treat them as equal citizens**

Critical reflection is at the centre of the triangle. It enables social workers to use their Knowledge, Skills and Interventions (and all other elements of the *Capabilities Statement)* effectively. It helps social workers to plan and decide what capabilities to draw upon in each practice situation; it assists them to learn and gain further knowledge from their practice experiences; and it supports consideration and weighing up of ethical decisions and dilemmas which are often central to social work with adults with learning disability.

The Capabilities

PURPOSE

The Purpose section of the PCF relates to 'Why we do what we do as social workers, our values and ethics, and how we approach our work.' It includes the domains: 2 – Values and Ethics; 3 – Diversity and Equality; 4 – Rights, Justice and Economic Wellbeing.

KEY MESSAGE

Good social work practice occurs when social workers skilfully combine personal values, behaviour, knowledge and skills to help people achieve the outcomes that mean the most to them.

People with lived experience said that they do not want 'professional relationship' to be defined narrowly. Social workers need the ability to work with a professionalism that includes warmth, empathy, care and authenticity, skilfully and ethically bringing themselves into the relationship.

Recognising strengths and empowering people

Effective social work starts from recognising the abilities of people with lived experience, drawing on strengths-based perspectives. Social workers should empower and support people to pursue their life choices, including everyday decisions – what to eat, wear, where to go – as well as potentially life changing judgements about accommodation, relationships, care, education, and health.

They should support people to maximise control over their own lives and over the services and care they receive through the principles of coproduction and collaboration. This should be upheld even in situations where a person's self-determination and control over their own care at first appears, or has been judged by others to be, very limited. Social workers are key rights advocates in these situations.

Social workers should:

- Be committed to involving people with lived experience – and their carers, families and friends where appropriate – in every issue related to their care, through co-production and collaboration.
- Support people to identify, build and use their own strengths and abilities.
- Put their values and ethics into practice through effective advocacy to ensure blocks to people using their strengths and self-determination are removed.

PCF domain:

2 Values and Ethics

Promoting rights-based practice

Historically, many people with lived experience have been subjected to social exclusion and human rights abuses including in institutions, care services and the community and this risk continues to date (Joint Committee on Human Rights, 2008).

Social workers need to understand the entrenched nature of discrimination against people with lived experience and the many barriers they may face in achieving access to their rights. Social workers should uphold and promote access to the same human rights for adults with lived experience of learning disability as for any other citizens, embedding their values and ethics into rights-based practice that makes a difference to people's lives. This includes showing and developing commitment to promoting the right to family life, respect for their sexuality and sexual lives, right to choose their friendships, the right to make 'unwise decisions' when they have the mental capacity to do so, and the right to choose their own lifestyles.

Social workers should also seek legal redress for people when necessary and understand the range of relevant entitlements and legislation. Social workers must develop their advocacy skills to improve people's access to rights, entitlements and services. This may extend to supporting access to housing, welfare rights, healthcare, and employment support.

Social workers should:

- Develop an understanding of human rights legislation and welfare rights as they apply to people with lived experience of learning disability.
- Understand the particular kinds of discrimination and abuse that people with lived experience face and the impact of this.
- Develop ability to challenge all forms of discrimination and human rights abuses against people with lived experience.

PCF domain:

4 Rights, Justice and Economic Wellbeing

Respect and upholding dignity

Social workers should respect and enhance peoples' right to self-determination and dignity. People with lived experience involved in developing this *Capabilities Statement* said *'they [social workers] should listen to [your] needs, what you want and need, and notice' and '[they should] not be bossy'.*

Social workers should use the framework and protection of the Mental Capacity Act (2005) when a person lacks decision-specific capacity. Social workers should ascertain and follow an individual's previously expressed wishes, feelings, and choices where they do not have capacity to make current decisions. Social workers should seek consent and in situations where consent cannot be granted – for example in some safeguarding situations – they need to explain why and fully involve the person in as much of the processes and decision making as possible. To do this effectively, social workers need to know the person holistically.

Social workers have a particular role in ensuring services are commissioned, provided and reviewed to uphold dignity and rights. They are vital in leading on the oversight of service quality within multiagency service systems, shaping and challenging commissioning and care planning decisions as necessary.

Social workers should:

- Actively listen and learn about people's experiences, recognise people with lived experience are experts in their own lives, respond to their wishes, ensuring these inform social work decisions.
- Be empathetic and non-judgmental, using appropriate verbal and non-verbal communication skills summarising information.
- Challenge colleagues where necessary and be open to having their decisions and practice challenged by people with lived experience, their carers and families, changing their decisions where appropriate.

PCF domains:

2 Values and Ethics
3 Equality and Diversity
4 Rights, Justice and Economic Wellbeing

PRACTICE

The Practice section of the PCF is about 'What we do – the specific skills, knowledge, interventions and critical analytic abilities we develop to act and do social work'. It includes the domains: 5 – Knowledge; 6 – Critical Reflection and Analysis; 7 – Skills and Interventions. Drawing on these, this section of the *Capabilities Statement* explains the theoretical, empirical, and practice knowledge and the skills required to intervene positively in the lives of people with lived experience.

This part of the *Capabilities Statement* particularly relates to the Knowledge and Skills Statement for Social Workers in Adult Services.[2]

KEY MESSAGE

SKILLS AND INTERVENTIONS: '(It's about) relationship based social work practice. Social work with people with a learning disability differs from generic adult social work... With people with learning disabilities the social worker gets much more involved in the person's life, dealing with the small stuff, as well as the main issues/concerns/ area of need... mental capacity is considered on a day by day (minute by minute) basis... the social worker is the co-ordinator, working in partnership with all other professionals, families, providers and most importantly the person themselves.' Social work comment during consultation

Relationship-based practice

Social workers need to be able to develop, nurture, and manage their relationships with people who use services and their networks, including friends, families, and other professionals. Relationship-based practice requires skills in *building, maintaining and repairing, and ending relationships.*

Relationship-based practice with people with lived experience of learning disability

People with lived experience involved in co-producing the *Capabilities Statement* identified three aspects of relationship-based practice.

Building relationships: Being personable, listening, respecting wishes and feelings, and using value-based communication skills. This also includes being able to explain the role of the social worker within the multi-professional context and an ability to develop a personal relationship while keeping professional identity.

Maintaining and repairing relationships: Demonstrating empathy and understanding; showing willingness to listen to personal issues, allocating time for regular home visits and managing expectations. Social workers also need skills in fixing relationships with people with lived experience because they may fracture from differences of views. Alternatively, the end of professional relationships may trigger feelings of loss and disappointment which should be managed appropriately.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/411957/KSS.pdf

Appropriate ending of relationships: People with lived experience have frequent changes of social workers. People with lived experience involved in developing this *Capabilities Statement* suggested the following endings as appropriate: writing letters, home visits to inform and explain the end of the relationship, giving them copies of their care plan and explaining the work that will be carried out by the new social worker.

Social workers should:

- Be skilful in building shared understanding and trust in working relationships, using face to face communications where possible, appropriate written communication styles, eliminating jargon using language that is familiar.
- Display professionalism and use supervision and other sources of support to critically reflect on behaviour conducive to maintaining good relationships.
- Seek regular feedback from people with lived experience and their carers, colleagues, and managers about their approach and practice and act upon it.

PCF domain:

7 Skills and Interventions

Pursuing partnership and co-production

Good social work practice is dependent upon the building of an open and transparent relationship based on a foundation of trust and mutual respect. Social workers need to be able to utilise their relationship building and communication skills to build effective partnerships.

The Care Act 2014 statutory guidance defines co-production and identifies the role in implementing the legislation. Co-production is about developing equal partnerships with adults who have learning disabilities and social workers to ensure they're involved in all decisions about their care or support and all aspects of service provision and support. It also means understanding that adults with lived experience have the knowledge and experience to improve services for themselves and others. Coproduction is a move from 'doing to' and 'doing for' to 'doing with in an equal and reciprocal partnership' (TLAP, 2019). Co-production is the sharing of power equally between adults with lived experience and social workers and recognising that the person 'using' a service is also a direct and empowered contributor to their own solutions.

Social workers should:

- Understand co-production, the underlying principles and how to apply in practice.
- Ensure that people with lived experience are included in all aspects of social work intervention, service planning and delivery.
- Engage in critical reflection to explore the application of values of co-production in social work practice and apply learning to improve interventions.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions
2 Values and Ethics

Assessment, support and care planning

People with lived experience require support to realise their choices and protect their human rights. This means assessments and care planning approaches that work in partnership with the person, rooted in appreciating they are experts in their own lives.

High quality care planning and appropriate support is essential to ensure people can secure and stay in a place they consider home and live the lives they want. Social work should focus on people's strengths and preventing negative risks escalating.

Reducing the risk of restrictive options being considered by health and care professionals in multidisciplinary systems of care is crucial. Social workers are key advocates and will often be decisions makers (e.g. in commissioning) and should use their professional authority to prevent or end use of institutional and/or restrictive approaches wherever possible.

Social workers should embrace approaches to assessment and care planning that avoid a one-way process of 'question and answer'. Conversational two-way communications and personalised enquiry enable plans to be created together with the person and relevant family, supporters and advocates. This requires good interpersonal and relationship-building skills, empathy and curiosity integrated with knowledge, reflection and an understanding of relevant theory, law and evidence.

Conversations and assessments should be informed by strengths-based approaches focusing on people's abilities, their capacities to resolve issues in their lives, take decisions and express their wishes. Assessments should identify strengths that may lie in their social and support networks, focused on independent living and self-determination.

Social workers should work in partnership with an adult with lived experience to seek to find out:

- **who they are as a person**
- **what they can do**
- **what they want and need**
- **what makes them happy/content**
- **how they can maintain and enhance control over their care and support choices**

Working with people with lived experience of learning disability often requires use of adapted communications techniques to optimise creative conversations/communications and partnership working.

The integration of these approaches provide the foundation for confident, ethical professional judgements and a co-produced approach to assessment and care planning in which the person's expertise in their own lives comes to the fore in decisions and planning.

Professionals should share their knowledge freely with the people they support, and ensure information is provided in a timely way, in accessible formats.

Care planning needs to take account of the complex issues that affect quality of life and recognise the holistic support needed to overcome barriers and challenges of discrimination including access to health care. These include access to suitable accommodation; employment and recreational opportunities; support and inclusion of families and friends; intimate and sexual relationships; cultural and religious beliefs and activities; parenting and caring roles.

Social workers should:

- Develop their skills in strengths- and relationship-based assessment and care planning, rooted in partnership and creative conversations.
- Provide people with lived experience and their advocates and supporters (as appropriate) with accessible information including copies of assessments and care plans in appropriate formats.
- Ensure that rights-based care plans enable people with lived experience to live well and safely in the community, accessing ordinary life opportunities and determining how they live.

PCF domain:

7 Skills and Interventions

Communication skills

Communication with people with lived experience should be underpinned by professional values and ethics, because 'social workers hold a lot of organisational power... [and] power is closely bound up with language' (Boahen and Wiles, 2018). Thus, social workers' communication skills and methods should reflect the profession's values and ethics.

Social workers need to understand the different ways that people with lived experience communicate – for instance sign language, Makaton, Picture Exchange Communication System, and Talking Mats. Depending on their role, social workers may need to develop these skills themselves, but should have the generic capability to understand when a different form of communication may be needed, the types of communication and language aids and approaches available, and how to work effectively with interpreters and advocates skilled in those communication forms.

Social workers should reduce the use of jargon in all their communications.

From 'assessment' to 'conversation' and reducing jargon

"Recycle your jargon into easy read so everyone with a learning disability can understand what is being said about them" (Jill the Jargon Buster) Adult with Learning Disability

Language in important in social work. Simplifying and clarifying language and reducing jargon was a very important theme for the Stakeholder Reference Group. This needs to be taken seriously in social work practice. Some organisations have changed the words they use to describe work with citizens, removing unnecessary jargon. This applies to written, online and spoken communication.

Social workers should:

- Understand the unique communication preferences and methods of individuals with lived experience.
- Ensure that they provide accessible formats of information and documents such as assessments and care plans.
- Underpin their communication with positive social work values and ethics.

PCF domain:

7 Skills and Interventions

Understanding social, psychological and medical models of learning disability

Social workers need to understand the social, psychological and medical models of learning disability, how these shape services and the relative power they may have in determining support and service choices.

The **medical model** of learning disability includes the use of IQ and emphasis on diagnosis of a physical or developmental condition(s) (e.g. cognitive and neurological impairments). The focus is on treatment interventions and what can or cannot be changed through medications or other physical interventions.

Recognition of physical causes of learning disabilities, and of the physical health needs of people with lived experience, are important to ensure access to appropriate healthcare. Social workers should understand medical perspectives well enough to evaluate the value and limits and risks of a medical model.

However, the dominance of medical approaches to learning disability is often reported by people with lived experience, their families and advocates as leading to stigmatising and excluding attitudes and approaches, low expectations of achievement and self-determination, and persistent or increasing dependency on services and professionals.

People with lived experience who co-produced this *Capabilities Statement* particularly emphasised the importance of social workers acting to challenge overt and unhelpful/limiting medical approaches to learning disability.

Psychological approaches focus on the emotional and cognitive needs and abilities of people with lived experience, and how these relate to behaviours and mood. Skilled identification, assessment and support for psychological needs can be a vital part of a personalised relationship-based approach. This can be integrated into a psycho-social approach that recognises common human psychological needs of people with lived experience – such as needs for healthy attachment, emotional expression, security, affirmation and positive relationships with others.

Social workers should understand the importance of understanding people's psychological realities, strengths and needs, their communication requirements to express their emotions and thoughts, and their right to equal access to psychological support and services.

The **social model of disability** emphasises that people's experience of the world and their opportunities to live well, flourish and have control over their lives, are primarily determined by societal barriers such as:

- oppression and stigma
- lower incomes

- poorer housing
- poorer access to 'social capital' such as informal support and safe, welcoming communities
- risk of abuse and exploitation
- inappropriate or inadequate services that do not understand needs and strengths of the person
- lack of access to advocacy and upholding rights and entitlements

Social workers' roles include fully understanding and applying the social model of disability (Stevens, 2008), promoting inclusion and person-centred practice while understanding the influence – the value and risks – of other models of learning disability. This includes enabling people to self-define their needs and strengths and express themselves in their own language and forms of communications.

Social workers should:

- Understand and know how to apply social and rights-based models and approaches in day to day practice to advocate for social justice, inclusion, rights and resources.
- Understand how different models and perspectives on learning disabilities shape and influence assessments, interventions and care planning.
- Understand why self-definition is important to people with lived experience and appreciate the terminology used by individuals, families and organisations.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions

Mental capacity best practice

In a survey of social workers during the development of this *Capabilities Statement* knowledge of mental capacity was a top priority. This is a complex interdisciplinary[3] area of practice touching on profound questions about individual autonomy, the law (the rights of people to make decisions for themselves and safeguarding duties towards those who are considered not to have decision specific mental capacity as enshrined in the Mental Capacity Act, 2005 and medicine (which addresses the 'mental disorders' that impair cognitive capacity (Owen et al, 2009)). There are also profound ethical issues about whether, when and how professionals should intervene in the lives of those who are viewed as unable to decide about their own care and treatment (Law Commission, 2017). As more people live in the community with complex needs, mental capacity is increasingly an important area of practice.

To practice ethically and legally, social workers need technical skills – for instance the use of tools and aids to elicit responses while assessing cognitive capacity. They also require decision-making skills such as determining the most appropriate time and place to conduct capacity assessments; observation skills to interpret body language and cues, and judgement skills to determine whether, on the balance of probability, the person with lived experience has decision making capacity. To be effective, social workers need information skills to research relevant law and the underpinning ethical principles. Social workers also require court skills, including, report writing, case management, and presentation. Overall, the work should be underpinned by a strong value-base and adherence to The Code of Ethics for Social Work[4].

[3] https://autonomy.essex.ac.uk

[4] https://www.basw.co.uk/system/files/resources/Code%20of%20Ethics%20Aug18.pdf

Social workers should:

- Know about the historical, theoretical, and ethical contexts of mental capacity practice, supported decision-making, and human rights.
- Understand the key principles of the Mental Capacity Act 2005 and the Liberty Protection Safeguards and their interface with the Care Act 2014 and Mental Health Act 1983.
- Engage in regular reflection on the complex ethics of social work practice concerning mental capacity.

PCF domains:

6 Critical Reflection and Analysis
7 Skills and Interventions

Understanding and intervening in health inequalities

People with lived experience overall have much worse physical and mental health and poorer wellbeing than the rest of the population (Rickard and Donkin, 2018). These health inequalities include increased and early mortality, intentional and institutional barriers to good healthcare, medical interventions without consent, and reduced access to palliative care. For instance, people with lived experience of learning disability have increased risk of co-morbidity and mortality – 13 to 20 years earlier for men and 20 to 26 years earlier for women (Hatton et al, 2016).

Health inequalities also have adverse consequences for peoples' mental health (Karban, 2016) and consequently, 40% (28% if behaviour that challenges is excluded) of people with lived experience of learning disability have mental illness (National Institute for Care Excellence, 2016). Therefore, social workers need to understand the social determinants of health and wellbeing and develop skills to advocate for people with lived experience.

Understanding how people with lived experience communicate and express their health needs is crucial to ensuring their health needs can be better met, earlier and more effectively.

Social workers should:

- Understand the factors causing poor health outcomes for people with lived experience of learning disabilities and use anti-oppressive practice and advocacy to enable access to appropriate services.
- Promote the rights of people to make decisions and choices in health and social care enshrined in the Mental Capacity Act 2005 and the Care Act 2014.
- Understand and promote assisted and tailored communications and technologies to improve access, uptake and appropriate use of healthcare by people with lived experience.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions

Knowledge and skills in safeguarding

People with lived experience are more at risk than the rest of the population of some forms of abuse, often because of social isolation and exclusion, the predatory and exploitative behaviours of others and the ineffectiveness of services in listening and acting early on what people say of their experiences.

Social workers need to know about the increased prevalence of some safeguarding issues with people with lived experience and the particular forms these can take – for instance sexual exploitation and abuse, grooming, being drawn into 'gangs' and extremism, financial and domestic abuse, and neglect. There is increasing attention on the risks of 'forced marriage' for some people with learning disabilities (Clawson and Vallance, 2010). Social isolation, poverty, unsuitable housing, and poor health for people with learning disability increase susceptibility to harm.

People may be at risk of 'hate crimes', in community or institutional settings, on the basis of their learning disability. This may be compounded by other forms of discrimination or abuse such as racism, homophobia or sex-based crimes. People with lived experience may have multiple personal identities leading to multiple and compounding discriminations.

The way that services, institutions and regimes of 'care' operate can also pose safeguarding risks for people. For instance, where services have difficulties responding to the needs and expressive behaviours of people with lived experience, this may increase the use of restrictions and restraining techniques which can cause harm and become patterns of abusive, institutional behaviour, often behind closed doors. This persists despite high profile examples of failures of care and abuse.

From institutions to community living: the role of the social worker

Social workers were key within the multidisciplinary efforts of deinstitutionalisation and asylum closures in the 1960s-1990s. The role of social workers in enabling people with disabilities to lead empowered, self-determined lives in communities is as important now as it was then.

In 2011, an undercover journalist secretly filmed physical and emotional abuse of adults with learning disabilities and autism at Winterbourne View private hospital in Bristol run by Castlebeck. The footage captured some of the hospital's most vulnerable patients being repeatedly pinned down, slapped, dragged into showers while fully clothed, taunted and teased by staff.

In 2019, another Panorama journalist secretly filmed a disturbingly similar pattern of abuse at Whorlton Hall in County Durham.

A separate 2019 CQC Review of seclusion found 62 adults and children, some as young as 11, were being held in isolation, sometimes for years.

These examples, in addition to showing failures in the regimes and staffing within particular hospital facilities, also show failures in health and social care commissioning and review. People should not be in long stay, inadequate, at worst abusive institutions. Alternatives to institutional care should be available and any use of institutional/hospital placements should be subject to vigorous and skilled review to curtail such use, including social work review.

Restrictions on ordinary life choices (such as bedtimes in residential care or non-provision of chosen food) within families or formal care arrangements can be harmful and may become a safeguarding and/or care quality concern. Social workers should be alert to the prevalence of multiple micro-restrictions and 'small' breaches of rights to self-determination and work in part partnership with the person with lived experience to tackle these.

Making Safeguarding Personal

Making Safeguarding Personal ensures an organisation's approach to safeguarding:

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety

Making Safeguarding Personal must not simply be seen in the context of a formal safeguarding enquiry (Care Act, 2014, Section 42 enquiry 2), but also in the whole spectrum of activity, embedded in preventive care and support as well as framing interventions when things go wrong.

Enabling people with lived experience of learning disability to maximise their abilities to safeguard their own wellbeing – by recognising risks and their right to be safe, raising issues with trusted supporters and advocates as soon as they have a concern, and knowing where to go for help – is also key to a personalised approach to safeguarding.

Social workers should:

- Understand and apply legal safeguarding duties under the Care Act 2014 and the Mental Capacity Act 2005.
- Be able to assess, review and intervene in the safety and suitability of care and accommodation arrangements for people with lived experience of learning disability, including multiagency and multi-professional contexts.
- Use critical reflection and analysis to determine and ensure safeguarding plans can be made to enhance the liberty of people with lived experience, promote proportionate and least restrictive practices and involve them in the spirit of '*Making Safeguarding Personal*'.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions

Knowledge and application of law

Social workers need to understand the main statutory legal frameworks including case law and precedents relevant to learning disability services and the rights of individuals and families.

Social workers need knowledge and skills in supporting people with lived experience and their families to navigate legal systems to ensure access to services and rights. Current key relevant laws (and their Codes of Practice) in England include:

- The Care Act 2014
- Mental Health Act 1983 (as amended 2007)
- Human Rights Act 1998
- Equality Act 2010
- Children Act 1989
- Children and Families Act 2014
- Children and Social Work Act 2017
- Child with special education needs and disabilities (SEND) guidance
- Mental Capacity Act 2005, including Liberty Protection Safeguards

Social workers should:

- Have in-depth understanding of the Care Act 2014 as the main legislation in adult social care, and how it interfaces (in particular) with the Mental Capacity Act 2005, the Mental Health Act 1983 (as amended 2007), and other relevant adult and children's legislation.
- Regularly refresh their knowledge of legislation (including case law, new guidance, and regulations) through regular CPD.
- Regularly reflect and understand the interplay between laws, the values, ethics and practices of social work; and how these can be drawn upon to improve the lives of people with lived experience.

PCF domain:

5 Knowledge

Applying knowledge of life transitions

"Social workers should understand that transition affects the whole family" (Carer)

Social work is often about supporting people through changes and challenges in transitions through life stages.

At specific chronological ages people with lived experience of learning disability transition between services – for example, at 18 years when they transition from children to adults' services and from adults to older adults' services. This can mean significant change in their lives and their care arrangements, impacting them as individuals and their families. They may experience a change in the nature and types of services available and a change in people involved in their care requiring new relationships with care providers to be formed.

People with lived experience who co-produced this *Capabilities Statement* wanted to draw attention to the multiple forms of transition that they experience – for instance, between hospital and their home, from care institutions to their home (for example moving between short-break care, palliative care, and medical care), and even between different teams and professionals within the same service – and the impact of each transition. Each transition requires personalised, person-centred transition planning. The implications for the individual, their family and support network need to be understood and considered in the planning for the transition.

While all people experience transitions from childhood to adulthood, for people with lived experience of learning disability, this can be significantly and qualitatively different than for the general population. Social workers need to support people with lived experience of learning disability to have as much control as possible through change, to express their wishes and be heard, to use their abilities and to have tailored support for change. Where change becomes challenging, social workers are key to listening and enabling people to express this, identify what might help, and seek improvements in support and services.

People with lived experience may not demonstrate the expected cognitive and social skills norms commensurate with their chronological age. Professional, family and public judgement may mean the social status of adulthood is conferred onto them later, or they may experience being perpetually judged as 'less than adult'. Their adult needs and wants – such as changing recreational and social interests, expectations of more independence, the wish for peer friendships and close and sexual relationships – may be rejected or ignored.

Social workers need to use their critical reflection and analysis capabilities to develop their empathy and understand more closely the implications, meaning and emotional experience of change and transition from the person's perspective.

Social workers should:

- Understand the statutory and practice guidance and legal rights on transitions to adulthood. This includes the Children and Families Act 2014 (under which Education, Health and Care Plans have to be maintained until the age of 25) and the role of the Care Act 2014 and the Mental Capacity Act 2005 in transition planning.
- Understand the practical and emotional impact of transitions and ensure person-centred planning focuses on the expectations, experiences, abilities, rights and control of the person.
- Advocate for change and improvement when the experience of transition between services is inadequate, at individual and systems levels.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions

The Named Social Worker pilots

The Department of Health and Social Care (DHSC) initiated the Named Social Worker (NSW) pilot to build an understanding of how having an NSW can contribute to individuals with learning disabilities, autism and mental health needs achieving better outcomes. The NSW pilot aimed to evaluate how people using services and their family could be more in control of decisions about their own future and better supported to live with the dignity and independence for which we all strive by having a consistent named worker.

The pilot sought to change social work practice and wider system conditions to improve outcomes and experiences for individuals in the cohort and for the people around them.

Phase 1 of the pilot ran from October 2016 to March 2017 and involved six pilot sites – Calderdale, Camden, Hertfordshire, Liverpool, Nottingham and Sheffield. The second phase of the pilot ran from October 2017 to March 2018 and involved Bradford, Halton, Hertfordshire, Liverpool, Sheffield and Shropshire.

Despite the short pilot time frame, the evaluation evidence suggests that the NSW pilot had significant impact at three levels

1. The individuals and the people around them:
    - had increased opportunities to feed into their person-centred plans in ways that met their communication needs and over a time period that helped them build consistent and trusting relationships with their NSW
    - felt that their NSW listened to them and acted on their behalf across the other people involved in their lives and
    - felt that NSW was putting measures in place that met their needs and those of the people around them to live a good life in the future.

2. The NSWs:
    - practised the knowledge, skills and values necessary to do good social work with people with learning disabilities, autism and mental health conditions
    - were protected by the NSW pilot structure, so that good social work happened in practice and
    - reported significant increases in confidence over the pilot and through the elevated status of the role, were more motivated and reported greater job satisfaction.

3. NSW pilot sites:
    - explored and deconstructed specific policy issues or objectives and piloted new ways of working
    - engaged a wider body of stakeholders to tackle systemic practice and/or improve processes and
    - built up an evidence base of what good social work looks like in the local context.

More detail about these headline messages is presented in the following sections.

(SCIE and Innovation Unit 2018)

Supporting carers, family and friends

"Carers matter – we are here. Be honest with us, have a dialogue with us, don't dismiss us, we want to work together" (Carer)

In a survey of carers completed during the development of this *Capabilities Statement*, carers were asked what they would like from a social worker supporting their family member. Responses included:

- **"be a champion for their needs, work fairly and equally with carers."**
- **"be a caring, good listener, understand and be knowledgeable."**
- **"accept that we know our family member better and what works for them."**
- **"for them to understand their role and what they can and can't do and who can if they can't."**

Social workers need to develop effective relationships with family, friends and carers seeking to include their views in any assessment, review, care and support planning. Social workers must also seek to engage holistically to understand carers individual circumstances and ensure assumptions are not made about their ability to care. Carers own physical, emotional and economical wellbeing is fundamental to supporting an adult with learning disability and social workers must identify and respond to carers individual needs. It must be recognised that the needs of carers may fluctuate over time for instance the caring role may change during transition into adulthood or at times of poor health.

Family, friends and carers should be provided with sufficient information regarding financial and commissioning processes including openness about eligibility criteria to ensure they are fully informed in advocating for themselves, their friend or family member.

Social workers, adults with learning disabilities, their family, friends and carers alongside other professionals should all work together.

Social workers should:

- Understand, apply and promote the law, policy and local arrangements to support carers including the provision of carers assessments.
- Work in partnership with family, friends and carers to develop trusting relationships based on openness, honesty and transparency.
- Provide accessible information about finances, commissioning and decision making processes.

PCF domains:

5 Knowledge
6 Critical Reflection and Analysis
7 Skills and Interventions
4 Rights, Justice and Economic Wellbeing

IMPACT

This section is based on the Impact super domain of the PCF, which is about 'How we make a difference and how we know we make a difference. Our ability to bring about change through our practice, through our leadership, through understanding our context and through our overall professionalism.' It includes Domains 1 – Professionalism; 8 – Contexts and Organisations; 9 – Professional Leadership.

KEY MESSAGE

Professionalism: People with lived experience involved in co-producing the *Capabilities Statement* said social workers should demonstrate their professionalism by being:

Accountable: '[the] social worker shouldn't be scared to ask for guidance and support. I think that is [an] important [value]'.

Reflective: 'Knowing when to say sorry and learning from your mistakes'.

Motivated to care for them: '[to] navigate difficult paths [in my life]' and 'make time for me'.

Understanding and influencing the context of learning disability services

Social workers should be aware of the political, policy, and practice contexts of services provision and how these affect the experience of citizens using services. As professionals with intelligence from direct practice and specialist knowledge, social workers should seek ways to influence policy at local and national levels, to advocate for people with lived experience and their carers, families and friends and seek improvements in service quality.

Contemporary contexts and imperatives include:

- The impact of austerity on public services, housing and the welfare benefits system, reducing social care support for some people with lived experience and their families.
- Policy drivers in how services are organised such as: integration, personalisation, personal budgets, focus on promoting community- and home-based support, strengths-based approaches to practice.
- Imperative of reducing continuing use of residential and hospital placements, often at long distance from home areas, with specific concerns about ongoing reports of high levels of restrictive practices to manage behaviours deemed 'challenging' and inadequate, non-personalised care within institutions.
- The need to improve access to general healthcare and universal and specialist local services.
- Improving commissioning and regular review of care services, developing the role of social worker in overseeing quality, personalisation as well as financial efficiency.

Social workers work in multi-professional contexts and within diverse types of employing organisation. They should be able to describe and communicate their distinctive role and enable people to navigate and access services and statutory entitlements wherever they are employed in the system. They should also understand and be able to help people access sources of support within the community such as those delivered by the third sector and those available from informal community support and activity (e.g. informal and voluntary groups and sources of friendship), taking a community asset-based approach.

Social workers should:

- Understand how national policy drivers affect the configuration and availability of local services – for example austerity and increased emphasis on 'personalisation' – and how national policy drivers impact on people's experiences.
- Enhance multi-agency working skills through critical reflection and CPD activities and the development of influencing skills.
- Critically reflect on how organisational contexts impact on their roles – for instance the differences and core similarities of being a social worker in the Private, Voluntary and Independent sector and local authority or the NHS.

PCF domain:

8 Contexts and Organisations

Being accountable

Social workers should take ownership of fulfilling their statutory and professional responsibilities. This includes managing their workload, apologising for and redressing errors, and consulting and communicating with people with lived experience and their carers, families and friends about any changes to their care plan. They should also maintain accountability to The Code of Ethics for Social Work[5]. People with lived experience involved in developing this *Capabilities Statement* included seeking managerial guidance and case management supervision as part of accountability.

Social workers should:

- Seek and prepare for regular practice supervision.
- Understand how the organisational and professional contexts affect their role and statutory duties.
- Engage in critical reflection to understand the power inherent in their role and how this can be deployed alongside people to empower them.

PCF domains:

1 Professionalism
8 Contexts and Organisations

[5] https://www.basw.co.uk/system/files/resources/Code%20of%20Ethics%20Aug18.pdf

Taking responsibility for self-care and continuous learning

This capability refers to social workers seeking support to manage the emotional demands of their role, planning and identifying time and mental space for learning, reflection and career development. While recognising the busy workload of social workers, they nevertheless need to allocate time for their CPD. This is essential for professional practice, for registration and for maintenance of wellbeing and resilience in the workplace.

Learning can occur in many forms such as through individual and group supervision, self-reflection and self-directed learning as well as formal taught and facilitated sessions face to face and online and the use of feedback from people with lived experience, carers and families, peers, supervisors and other stakeholders.

Employers have a responsibility to provide adequate training and supervision and there is corresponding need for professionals to take them up and/or advocate for appropriate provision.

Social workers should:

- Honestly and regularly appraise their capabilities and identify gaps they need to address.
- Plan their CPD regularly, considering their preferred learning styles and exploring opportunities to experience different forms and sources of learning, professional and personal development.
- In supervision and other appropriate forums, identify the work situations that cause stress and explore how these can be addressed.

PCF domains:

1 Professionalism
8 Contexts and Organisations
9 Professional Leadership

Professional leadership

Social workers have a lead role in improving care and support for people with lived experience of learning disability and their families. Within multidisciplinary teams and interagency systems, social work perspectives and values are essential to ensuring the person and their wellbeing are paramount – and that service, financial and professional interests do not dominate.

Social workers should:

- Identify their professional leadership learning needs and plan CPD opportunities to address these.
- Identify the particular challenges and opportunities for practice leadership and influence within the learning disability sector.
- Develop collective leadership and networking for peer support and to increase influence to resolve complex issues within organisations and systems.

PCF domains:

8 Contexts and Organisations
9 Professional Leadership

References

ADASS, LGA, IPC, RiPfA (2018) Making Safeguarding Personal (MSP) outcomes framework.

Boahen, G., & and Wiles, F. (2018). *Professionalism and Self-management*. London: McGraw-Hill Education.

British Association of Social Workers. (2018) *Professional Capabilities Framework – social work level capabilities:* www.basw.co.uk/pcf/PCF05SocialWorkLevelCapabilities.pdf (accessed 17 May 2019).

British Association of Social Workers. (2014). *The Code of Ethics for Social Work.* www.basw.co.uk/about-basw/code-ethics (accessed 17 May 2019).

Clawson, R., & Vallance, P. (2010). *Forced Marriage and Learning Disabilities: Multi-agency practice guidelines.* HM Government.

Department of Health. (2015). *Knowledge and Skills Statement for Social Workers in Adult Services* www.gov.uk/government/uploads/system/uploads/attachment_data/file/411957/KSS.pdf (accessed 17 May 2019).

Department of Health (2019) *Strengths Based Approach: Practice Framework and Practice Guide.*

Hatton, C., Glover, G., & Emerson, E and Brown I. (2016). *People with Learning Disabilities in England 2015*. London: Public Health England.

Joint Committee on Human Rights (2008). *A Life Like Any Other: The Human Rights of Adults with Learning Disabilities*. The Stationery Office Ltd; London: UK.

Karban, K. (2016). Developing a Health Inequalities Approach for Mental Health Social Work. *British Journal of Social Work, 47*(3), 885-992.

Law Commission. (2017). *Mental Capacity and Deprivation of Liberty* https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2017/03/lc372_mental_capacity.pdf (accessed 17 May 2019).

National Institute for Health and Care Excellence. (2016). *Transition from Children to Adults' Services for Young People using Health or Social Care Services* www.nice.org.uk/guidance/ng43/resources/transition-from-childrens-to-adults-services-for-young-people-using-health-or-social-care-services-pdf-1837451149765 (accessed 17 May 2019).

Owen, S. G., Freyenhagen, F., Richardson, G., & Hotopf, M. (2009). Mental Capacity and Decisional Autonomy: An Interdisciplinary Challenge. *Inquiry, 52*(1), 79-107.

Rickard, W., & Donkin, A. (2018). *A fair, supportive society: Summary report* www.instituteofhealthequity.org/resources-reports/a-fair-supportive-society-summary-report (accessed 17 May 2019).

SCIE and Innovation Unit (2018) Named Social Worker Pilot. Programme Evaluation: Final Report.

Stevens, A., R.A. (2008). Social Models of Disability and Social Work in the Twenty-first Century. *Ethics and Social Welfare., 2*(2), 197-202.

TLAP (2019) What Makes Co-production Different? www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-makes-co-production-different (accessed 5th June 2019).

www.basw.co.uk

Continuing professional development pathway for

Social Workers Working with Adults with Learning Disability

Department of Health & Social Care

BASW England

The professional association for social work and social workers

Introduction

This Continuing Professional Development (CPD) Pathway for social workers working with adults with learning disability is an innovative and practice-focussed post-qualification training framework, which is underpinned by principles of co-production. Commissioned by the Department for Health and Social Care, it has been developed following extensive consultations with social workers, people with lived experience, employers, and academics, to identify the capabilities required for rights-based social work practice with adults who have learning disability.

This Continuing Professional Development Pathway should be read in conjunction with the Capabilities Statement for Social Workers working with Adults with Learning Disability (2019)[1] which outlines the necessary knowledge, skills and values for effective social work practice. The Pathway encompasses the Professional Capabilities Framework (PCF)[2] which is the profession-owned, overarching framework of social work education and professional development in England as pictured below alongside supporting social workers to meet the expectations of the Chief Social Work for Adults in England's Knowledge and Skills Statement for Social Workers in Adult Services[3].

[1] www.basw.co.uk

[2] https://www.basw.co.uk/professional-development/professional-capabilities-framework-pcf

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/411957/KSS.pdf

Explaining Continuing Professional Development

Continuing Professional Development (CPD) is the way in which registrants continue to learn and develop throughout their careers so they keep their skills and knowledge up to date and are able to practice safely and effectively.[4]

Social workers require CPD for regulatory and ethical reasons. In England, in order to maintain their registration and legal title, social workers need to demonstrate their participation in regular CPD activities. However, there is also an ethical aspect of CPD, based on the premise that *in order to make positive impact for people with lived experience, social workers need to be trained in current knowledge and skills.*

An underpinning principle of this Pathway is that social workers should engage in lifelong learning and reflective practice. Furthermore, as social workers are required to evidence their CPD activities, they need to keep records and reflect on how they can demonstrate the positive impact of their learning.

Components of CPD

CPD includes trainer-led activities and self-directed learning – *it is about the content of the learning rather than how it is delivered.* It can include:

- Training facilitated by an approved trainer, a colleague, or person with lived experience
- Receiving formal and informal feedback from people who use services
- Self-directed learning through podcasts, videos, reading (for example, research articles, books, case records)
- Group supervision and peer-supported learning
- Online and web-based learning
- Insights gained from (self) reflection and evaluation
- Shadowing and observing colleagues and allied professionals
- Attending conferences

Employers should recognise the multiple sources and forms of learning and provide enabling CPD environments by ensuring access to learning opportunities.

[4] www.hcpc-org.uk/cpd/what-is-cpd/

Principles of the Continuing Professional Development Pathway

- People with lived experience of learning disability should be integral to planning, commissioning, and delivery of CPD programmes. This can be achieved by employers consulting them, social workers seeking (in)formal feedback about their work from them, and providers including them in training.
- A scaffolding approach is necessary to support social workers development– social workers should build incrementally on existing capabilities thus CPD should be commensurate with level of practice.
- Social workers with more experience in practicing with adults with learning disability will be assigned more complex work, however they will also have more practice wisdom. Consequently, practitioners at the level of ASYE and NQSW require training in foundational practice issues and those at latter stages of their career need CPD in 'complex' and strategic topics.
- Engaging in CPD activities is a professional and ethical responsibility, however correspondingly, employers should provide social workers 'protected time' for CPD.
- Social workers require a foundational value-base, knowledge, and skills which will be enhanced by CPD training.
- Good quality CPD requires appropriate support from:
    - The social work profession including social workers, supervisors, educators, academics, researchers, regulators, managers and leaders
    - Adults with learning disability, their family, friends and carers
    - Employers including supervisors, managers, leaders, Human Resources and workforce development
    - Government – local and national
    - Wider stakeholders and organisations

The Continuing Professional Development Pathway

Assessed and Supported Year in Employment (ASYE) / Newly Qualified Social Worker (NQSW)

ASYE level capabilities should be integrated into ASYE programmes - particularly where social workers are working significantly with people with lived experience of learning disability.

An ASYE social worker and their supervisors can use the whole Capabilities Statement as source material for wider learning and recognise the capabilities at social worker/experienced social worker level are ambitions for attainment when moving into/continuing in learning disability work post completion of the ASYE.

Social workers advance at different levels in their capabilities and some ASYE may well be able to demonstrate some capabilities at higher levels within their first one or two years of practice. However, the Capability Statement is designed to be stretching to meet the learning and practice needs of social workers post-ASYE and those experienced (or becoming experienced) in social work practice with adults who have learning disability and it will provide suitable post-NQSW challenge and stretching standards to improve day to day practice.

The ASYE level capabilities may also be relevant for more experienced social workers who move to a role supporting adults with learning disability following experience in other areas of social work practice.

Post-ASYE CPD framework

The capabilities contained in the Capability Statement for Social Work with Adults who have Learning Disability are written at what is termed 'The Specialist PQ' level. This is the level for social workers and experienced social workers (PCF level descriptors). The diagram and boxes below provide the outline of the whole CPD pathway from social worker to strategic level. Progression is mapped onto a conventional academic pathway – PGCert, PGDip, Masters – which it is proposed could also be pursued through a sector or professional body-led accredited route, with or without formal academic credits. This is in recognition that CPD needs to be available to all, flexibly and affordably, but also needs to meet standards. University provision is an important route, but other options and models are available including sector accreditation.

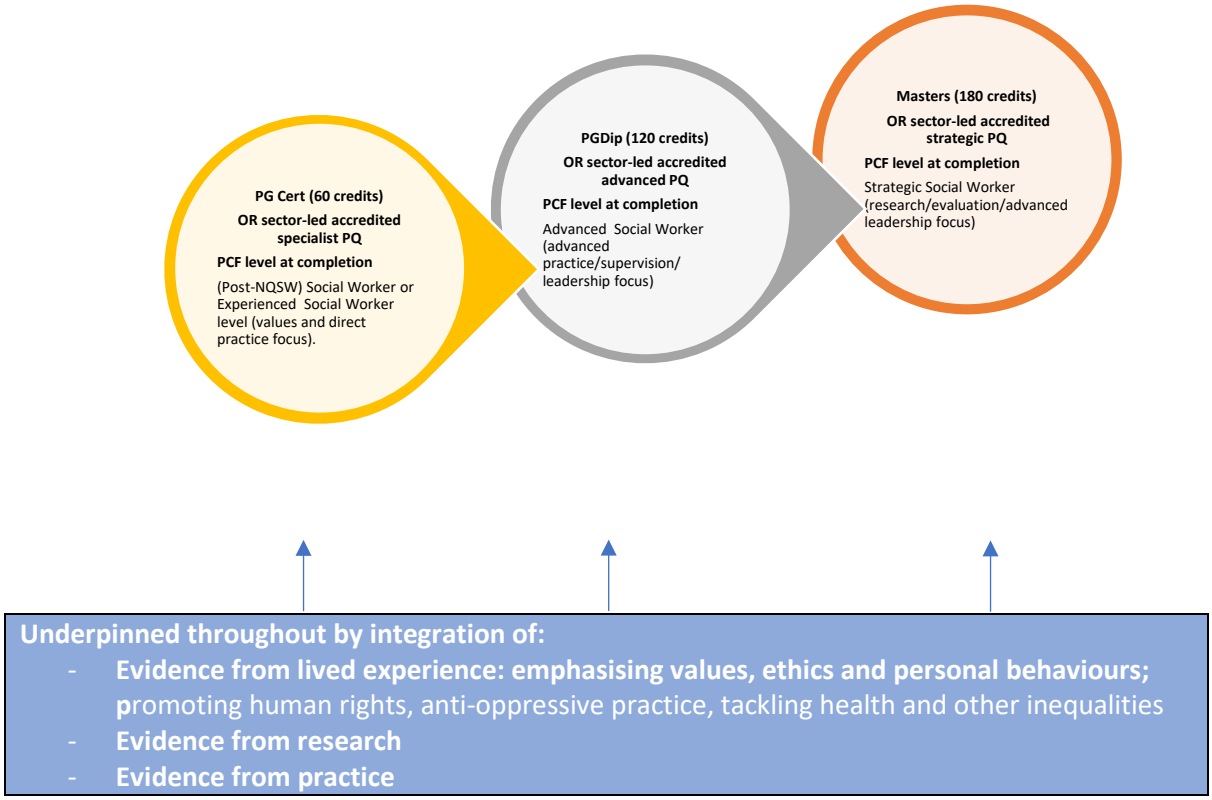
The terminology and educational elements proposed are:

- **Specialist PQ**: PGCert or sector equivalent - Social worker and experienced social worker level. *The aim is to ensure this level of learning and attainment is recognised and valued as 'specialist'. It should be core CPD as it will apply to most social workers in direct practice. It can stand alone or be the foundation for the PGDip and Masters.*
- **Advanced Post Qualification –** PGDip or sector equivalent – advanced and/or strategic level social worker. *It is proposed to combine the CPD offers at advanced and strategic levels for simplicity and to ensure strategic social worker development*

is connected with practice, and practice leadership is connected with strategy and wider/systems influence.

- **Strategic Post Qualification –** Masters or sector equivalent - advanced and/or strategic level social worker. *The emphasis is on wider and more strategic issues, service improvement and (essential for Masters level) engagement in knowledge productions through research and/or evaluation as well as higher level application of knowledge and evidence.*

Fig 1: CPD pathway - progression framework – HEI or sector led



Continuing Professional Development Pathway - Curriculum Level and Content

The Specialist Learning Disability Post-Qualification	The Advanced Learning Disability Post Qualification	The Strategic Disability Post Qualification
Likely time taken: 9-12 months part time Curriculum level: The Specialist Learning Disability Post Qualification is the level at which the Capability Statement is written. It is therefore the level which all social workers and experienced social workers should be attaining to practice well in the field of Learning Disabilities, augmenting the PCF and the Knowledge and Skills Statement (KSS) with focused knowledge, skills and other key capabilities.	Likely time taken: 18-24 months part time Curriculum level: The Advanced Learning Disability Post Qualification includes all the capabilities within the Capability Statement and augments these with the additional capabilities provided in the level descriptors document Appendix One. This level is aimed at both Advanced and Strategic social workers with a focus on practice, supervision and operational leadership.	Likely time taken: 24-36 months part time Curriculum level: The Strategic Learning Disability Post Qualification - includes all the capabilities within the Specialist and Advanced levels and augments these with additional capabilities as in Appendix one. This level is also aimed at both Advanced and Strategic social workers, but its focus moves on to research, evaluation and more advanced and strategic leadership which would include systems leadership and interagency impact. This reflects its position at master's level within academic context and the need for a relevant strategic influence and leadership focus for the most senior practice and strategic leaders and managers.
Curriculum content starting points: - Foundation bibliography within Capability Statements – online on DHSC and BASW websites - Literature and policy review and additional bibliography on BASW website - Written learning resources on distinct elements of the Capability Statement on BASW website - Webinar and podcast resources on BASW website - Mapping resources and integrating other key	Curriculum content starting points: - As for Specialist level - Additional materials on advanced practice, supervision and education/leadership/support of others in operational contexts - Focus on application of best practice evidence - Focus on practice with higher levels of complexity, ambiguity and risk - Emphasis on confidence and role-modelling good practice and values/ethics driven behaviours - Influence and practice leadership beyond social work, to interagency and multi professional contexts	Curriculum content starting points: - As for Specialist and Advanced levels - Additional materials on Strategic practice and organisational leadership, research/evaluation - Focus on systems leadership within and beyond single organisations, to interagency and community systems at all levels - Focus on strategic and lasting improvement - Integration of social work Capability Statement with wider

standards/frameworks with Capability Statement e.g. KSS, skills for care and skills for health competences.	- Quality evaluation, improvement and audit - Advanced responsibilities to show positive impact and outcomes at team or organisational level as well as individually - Advanced responsibility on understanding and responding to intersectional issues - Advanced partnership and co-production skills and knowledge, including advanced skills in community-oriented practice - Increased emphasis on understanding the wider landscape of social work practice with adults who have learning disability, partner organisations, key influencers and sources of good practice and innovations - Mapping onto Practice supervisors and practice leadership KSS	drivers, policy and imperatives including those for multiagency partners. - Further emphasis on sources of innovation and good practice for the future of services, across disciplines, while promoting the social work role and capability set.

Appendix One

Capabilities for Social Workers working with adults with Learning Disability – Level descriptors for Continuing Professional Development (CPD) Pathway and Outline Curriculum

1. Capabilities Statement for Social Work with adults who have learning disability at levels of the PCF and relevant CPD level

CPD programme	**ASYE programmes/first two years post-qualified CPD**	**PGCert or sector accredited equivalent – Specialist Post Qualification**	**PGDip or sector accredited equivalent (advanced practice/supervision/ leadership focus) and Masters (research/evaluation/ advanced leadership focus)**	**PGDip or sector accredited equivalent (advanced practice/supervision/ leadership focus) and Masters (research/evaluation/ advanced leadership focus)**
Capability title and relevant PCF Domain	**Newly Qualified SW**	**Social Worker / Experienced Social Worker**	**Advanced Social Worker**	**Strategic Social Worker**
i. Recognising strengths and empowering people *PCF Domain 2 – Values and Ethics*	Understand and learn how to apply a strengths-based approach in learning disability. Understand and apply the principles of the Mental Capacity Act 2005 with supervisory support.	Be committed to involving people with lived experience - and their carers, families and friends - where appropriate - in every issue related to their care, through skills in co-production and collaboration. Support people to identify, build and use their own strengths and abilities.	Model confident, advanced application of strengths-based approaches. Share knowledge and skills through supervision and support to social workers and others. Understand and support the development of a strengths-based value base and ethic	Create practice systems where strengths-based values and ethics underpin all work across the sector. Ensure organisational and interagency contexts support the development of services that are co-produced with adults who have learning disabilities, their carers, families and friends.

	Apply values and skills to involve people with lived experience and their carers and families where appropriate, in assessment, care planning, decisions and review.	Put values and ethics into practice through effective advocacy to ensure blocks to people using their strengths and self-determination are removed	within the team/ organisation/ interagency system.	
ii. Promoting rights-based practice *PCF Domain 3 – Rights, Justice and Economic Wellbeing*	Understand fundamentals of human rights legislation and how to apply rights-based approaches to social work practice including the right to make 'unwise decisions'. Understand the impact of discrimination and oppression experienced by adults with lived experience. Understand role of social workers in challenging discrimination and human rights abuses affecting people with lived experience.	Develop an understanding of human rights legislation and welfare rights as they apply to people with lived experience of learning disability Understand the particular kinds of discrimination and abuse that people with lived experience face and the impact of this Develop ability to challenge all forms of discrimination and human rights abuses against people with lived experience.	Model and promote confident and critical application of rights-based practice, particularly where there is particular complexity, ambiguity, risk or dispute e.g. between professionals and/or family members. Undertake/commission, review and act upon practice and quality audits ensuring the promotion of rights is driving good practice with adults with lived experience. Develop systems of good practice across professions and agencies to uphold rights	Take strategic responsibility for leading and promoting rights-based practice. Regularly review rights-based practice system structure / service provision and co-produce any changes with people with lived experience, their carers, families and friends. Lead, research or evaluate good practice locally and elsewhere and disseminate learning to encourage best possible outcomes.
iii. Respect and upholding dignity	Develop relationships based on openness, honesty and	Listen closely and hear about people's experiences, recognise they are experts in	Model and promote good practice to support social	Take strategic responsibility for promoting respect and

PCF Domains 2 – Values and Ethics	transparency with adults who have learning disability, families, carers and other professionals.	their own lives, respond to their wishes, ensuring these inform social work decisions Be empathetic and a non-judgmental, using appropriate skills in verbal and non-verbal communication, summarising, and reflection. Challenge colleagues where necessary and be open to having their decisions and practice challenged by people with lived experience, their carers and families, changing their decisions where appropriate.	workers to develop necessary skills. Undertake/commission, review and act upon practice and quality audits ensuring the promotion of respect and upholding dignity for adults with lived experience. Develop systems of good practice across professions and agencies to uphold dignity and respect.	dignity for adults with learning disabilities Regularly review respect and dignity in the system structure / service provision and co-produce any changes with people with lived experience, their carers, families and friends. Lead, research or evaluate good practice locally and elsewhere and disseminate learning to encourage best possible outcomes.
iv. Relationship-based practice: *PCF Domain 7 – Skills and Interventions*	Develop effective communication and relationship-building skills. Engage in critical reflection to further develop relationships. Seek and apply feedback from people with lived experience about the value and effectiveness of working relationships	Are skilful in building shared understanding and trust in working relationships, using face to face communications where possible, appropriate written communication styles, eliminating jargon using language that is familiar. Display professionalism and use supervision and other sources of support to critically reflect on behaviour conducive	Promote relationship-based practice through providing and/or enabling appropriate supervision, peer support and other reflection. Promote the evidence base for relationship-based practice and interpersonal skills and explore innovations and good practice examples in this field with colleagues. Implement systems which allow feedback on the quality	Strategically promote relationship-based practice ensuring the culture exists which promotes effective and valued working relationships being built and sustained. Undertake leadership in educating colleagues within the organisation and interagency system around the value of relationship-based approaches.

	to support ongoing professional development.	to maintaining good relationships. Seek regular feedback from people with lived experience and their carers, colleagues, and managers about their approach and practice and act upon it.	and effectiveness of working relationships from people with lived experience, carers, families and friends, and from colleagues, for workers, teams and services.	Use leadership skills to develop creative and innovative social work practice.
v. Pursuing Partnership and Co-production *PCF Domains 5 - Knowledge 6- Critical Reflection and Analysis 7 - Skills and Interventions 2 -Values and Ethics*	Develop understanding of partnership and co-production with people lived experience, their carers, families and friends. Develop skills in promoting partnership and co-production in design and delivery of social work support and interventions. Apply critical reflection and analysis skills to experience of pursuing partnership and co-productively.	Understand co-production, the underlying principles and how to apply in practice. Ensure that people with lived experience are included in all aspects of social work intervention, service planning and delivery. Engage in critical reflection to explore the application of values of co-production in social work practice and apply learning to improve interventions.	Develop partnership and co-production as underpinning principles and approaches to all aspects of social work. Develop skills to demonstrate effective partnership and co-production and to supervise and guide others. Engage in critical reflection to identify successes, challenges and gaps in approaches to partnership and co-production and make response to these.	Take responsibility for ensuring social work services are co-produced from design stage and that this continues through processes of review and evaluation. Ensure a co-production ethos is promoted throughout all social work provision. Ensure strategic commitment to providing the right contexts, resources and processes are in place to work closely and consistently with people with lived experience, their carers, families and friends (e.g. through valued locality partnership and co-production forums).
	Develop abilities in strengths-based	Develop their skills in strengths- and relationship-	Provide leadership in facilitating and modelling	Ensure social workers and others are able to access

vi. Assessment, support and care planning *PCF Domain 7 – Skills and Interventions*	assessment and support planning including building effective relationships, using appropriate communications and conversational approaches; working in partnership with people with lived experience, their carers, families and friends. Provide people with lived experience copies of assessments and care plans in accessible formats. Understand the range of support options open to people and how these options can be taken forward through maximising choice and control.	based assessment and care planning, rooted in partnership and creative conversations Provide people with lived experience copies of assessments and care plans in accessible formats. Ensure that rights-based care plans enable people with lived experience to live well and safely in the community, accessing ordinary life opportunities and determining how they live.	good, evidence-informed practice to co-produce assessment, care plans and interventions/support alongside people with learning disabilities, their carers, families and friends. Have a thorough understanding of and promote the use of least restrictive care and support options and innovations including Share Lives, direct payments and personal health budgets.	continuing education and training, informed by evidence from research, practice and lived experience, to develop professional assessment, support and care planning skills and best practice. Apply expert knowledge about people with learning disability to strategic decision making about assessment, support and care planning systems and approaches.
vii. Communication Skills *PCF Domain 7- skills and Interventions*	Develop understanding of the variety of interpersonal and technical communication approaches most	Understand the unique communication preferences and methods of individuals with lived experience. Seek to develop skills and experience in using accessible	Enable social workers to continually develop their communication skills and ensure processes exist for accessible documents and other appropriate	Take strategic oversight for ensuring services use appropriate and effective communications consistently with people with lived experience, their carers, families and friends. Ensure

	relevant to people with lived experience. Develop skills in preparing accessible, jargon-free document and other accessible communication methods.	communication methods e.g. Makaton, Picture Enhanced Communication, Talking Mats and assistive technology. Ensure that they provide accessible formats of information and documents such as assessments and care plans. Underpin their communication with positive social work values and ethics.	communication resources to be produced. Model and develop relevant expert use of accessible communication methods e.g. Makaton, Picture Enhanced Communication, Talking Mats and assistive technology. Maintain knowledge of emerging practice and new resources, including new technology.	development opportunities are available for social workers and others within organisations and across interagency systems.
viii. Understanding social, psychological and medical models of learning disability *PCF domains 5 – Knowledge; 6 – Critical Reflection and Analysis; 7 – Skills and Interventions*	Understand and apply the social model of disability. Understand essential components of the psychological and medical models and how these relate to the social model, including how different language, terminology and concepts affect experiences and service systems.	Understand and know how to apply social and rights-based models and approaches in day to day practice to advocate for social justice, inclusion, rights and resources. Understand how different models and perspectives on learning disabilities shape and influence assessments, interventions and care planning. Understand why self-definition is important to people with lived experience and appreciate the	Advanced application of the social model and ability to share good practice and develop learning opportunities. Develop culture of critical reflection to support analysis of how different models of disability influence social work.	Provide leadership to the application of the social model and ensure its impact in strategic decision making, monitoring benefits and outcomes.

		terminology used by individuals, families and organisations.		
ix. Mental capacity best practice *PCF Domain 7 – Skills and Interventions.*	Develop knowledge and application of the Mental Capacity Act and supported decision making. Use supervision effectively to explore the complexities of the ethical and legal dimensions of mental capacity practice.	Know about the historical, theoretical, and ethical contexts of mental capacity practice, supported decision-making, and human rights. Understand the key principles of the MCA and the Liberty Protection Safeguards and their interface with the Care Act 2014 and Mental Health Act 1983. Engage in regular reflection on the complex ethics of social work practice in mental capacity.	Provide oversight and critical challenge to social work practice to ensure good mental capacity practice. Effectively support social workers to critically reflect and explore complex mental capacity decision making. Develop relationships with allied professionals to support and develop their understanding of mental capacity ethics and legislation.	Provide leadership and develop best practice models regarding mental capacity at strategic, organisational and interagency levels. Ensure developmental opportunities and ongoing learning are available across the system.
x. Understanding and intervening in health inequalities *PCF domains 5 – Knowledge; 6 – Critical Reflection and Analysis; 7 – Skills and Interventions*	Develop understanding of health inequalities and how to address these for people with lived experience within service systems and processes. Contribute to professional and organisational learning through critical reflection on own and	Understand the factors behind worse health outcomes for people with lived experience of learning disabilities than the general population. Understand and apply anti-oppressive practice to redress health inequalities such as advocacy and enabling people to have their voices heard, at individual and service system	Confidently lead discussions and challenges where it appears that service systems or practice from health professionals or institutions risks disadvantaging, devaluing or oppressing people with learning disabilities. Ensure social workers are supported to be able to confidently challenge inequalities and promote	Deliver professional social work leadership within a multi-agency context to challenge health inequalities, seek redress through anti – oppressive practice and promote good practice through developing a high quality, rights-based, outcomes-focused learning culture across interagency systems.

	others' practice to understand what went right/wrong in practice and how to improve future practice, especially in cases of poor health outcomes for people with lived experience.	levels, promoting the rights of people to make decisions enshrined in the Mental Capacity Act 2005 and the Care Act 2014. Understand how assistive and tailored communications technologies can be ethically and appropriately used in healthcare of people with lived experience.	service systems that protect the health rights of individuals. Lead learning exercises and develop learning cultures to understand what went right/wrong in practice and how to improve future practice in cases of poor health outcomes for people with learning disabilities (e.g. LeDeR Reviews). Understand and promote good practice in healthcare for people with lived experience including through promoting better assistive and communications technologies and co-production in healthcare.	
xi. Knowledge and Skills in Safeguarding *PCF domains 5 – Knowledge; 6 – Critical Reflection and Analysis; 7 – Skills and Interventions*	Enhance safeguarding skills and knowledge through working alongside experienced colleagues and effective use of supervision, critical reflection and analysis. Develop skills in positive approaches to risk assessment, optimising	Understand and be able to apply their legal safeguarding duties under the Care Act 2014 and the Mental Capacity Act 2005. Understand how to assess and intervene in the safety and suitability of care and accommodation arrangements for people with lived experience of	Provide professional leadership of safeguarding good practice Deliver 1 to 1 and group supervision (or other forms of professional support) which enables critical reflection to consider safeguarding practices, liberty, proportionality and least restrictive principles.	Provide strategic oversight of approaches to safeguarding promoting positive risk taking and individual liberty in the spirit of '*Making Safeguarding Personal*' Ensure organisational and interagency systems and cultures encourage reflection and learning.

	choice and control and ''*Making Safeguarding Personal',* and explore ethics of safeguarding.	learning disability, including multiagency and multi-professional contexts. Use critical reflection and analysis to determine and ensure safeguarding plans can be made to enhance the liberty of people with lived experience, promote proportionate and least restrictive practices and involve them in the spirit of '*Making Safeguarding Personal*'.	Have a comprehensive understanding of law, national and local policies and how safeguarding fits with other practices and duties (e.g. strengths based and relationships-based practice; rights-based practice; personalisation) and provide leadership on this for social workers and others.	Influence own organisation and inter-professional and interagency systems to ensure safeguarding good practice is embedded and actioned to prevent abuse and resolve care failures.
xii. Knowledge and application of law *PCF Domain 5 – Knowledge*	Understand relevant fundamental legislation in social work practice (e.g. Care Act 2014 and Mental Capacity Act 2005) and develop an increased understanding of how statutes work together and are applied in social work practice. Use supervision and peer support to explore ethics and values in relation to the law.	Have in-depth understanding of the Care Act 2014 as the main legislation in adult social care, and how it interfaces (in particular) with the Mental Capacity Act 2005, the Mental Health Act 1983, and the Children Act 1989. Update their knowledge of legislation (including case law, guidance, and regulations) through employer-provided and independent CPD activities. Regularly reflect and understand the interplay	Have extensive knowledge of legislation and guidance and support others to develop this. Provide systemic supervision, peer and/or other support to social workers and others which explores and explains the links between legislation, social work value, ethics and outcomes Keep up to date with legal developments e.g. through case law and amendments.	Use knowledge and application of the law to provide strategic leadership rooted in application of the principles of key legislation and associated guidance/Codes of Practice (e.g. the Care Act 2015, Mental Capacity Act 2005 and Mental Health Act 1983).

		between laws, the values and ethics of social work; and how these can be drawn upon to improve the lives of people with lived experience.		
xiii. Applying knowledge of life transitions *PCF domains 5 – Knowledge; and 6 – Critical Reflection and Analysis; and 7 – Skills and Interventions*	Develop an understanding of best practice in supporting individuals at times of transition, including end of life care. Understand that transitions occur throughout the lifespan and that person-centred approaches are essential.	Understand the statutory and practice guidance and legal rights on transitions to adulthood. This includes the Children and Families Act 2014 (under which Education, Health and Care Plans have to be maintained until the age of 25) and the role of the Care Act 2014 and the Mental Capacity Act 2005 in transition planning. Ensure person-centred transition planning focused on the expectations, experiences, abilities and control, including end of life care. Advocate for change and improvement when the experience of transition between services is inadequate.	Develop and share a strong knowledge and skill base regarding life transitions practice with social workers and others. Identify, develop and strengthen strategies, processes and professional practices to support adults with learning disabilities and their carers, families and friends at times of transition throughout the life span, (including end of life care), through co-production approaches.	Develop and implement strategic and critical evaluation of transition experiences and promote improvement in professional support and processes within organisations and across interagency systems. Ensure evaluation and service changes are developed and delivered through co-production approaches.
xiv. Supporting carers, families and friends	Demonstrate a commitment to listening and understanding the	Understand, apply and promote the law, policy and local arrangements to support	Take responsibility for ensuring that social workers are knowledgeable and skilled	Take strategic responsibility to champion the role of informal carers and their rights and

PCF Domains 5 -Knowledge 6- Critical Reflection and Analysis, 7-Skills and Interventions, 4- Rights, Justice and Economic Wellbeing	views and individual situations which family, friends and carers experience. Understand the legal and policy frameworks that provide for carers and families. Enable carers, families and friends to access their entitlements and other services and supports available.	carers including the provision of carers assessments. Work in partnership with family, friends and carers to develop trusting relationships based on openness, honesty and transparency. Provide accessible information about finances, commissioning and decision-making processes.	about carers rights and have the skills and values to work in partnership with cares, families and friends. Provide supervision and other support to enable reflection on the nature, role and experiences of carers, families and friendship networks, recognising both legal and policy entitlements (e.g. for identified carers and/or people with power of attorney), and the potential importance of wider networks of family and social contacts. Ensure social workers understand the potential for support and harm from close family and other relationships. Ensure working relationships between social workers and carers, families and friends are reviewed to enable learning and accountability. Ensure successful working relationships and approaches are recognised and less	recognise the potential importance of wider family and friendship networks in the lives of people with lived experience. Ensure that processes regarding finances, commissioning and decision making are clear, open and transparent to carers, families and friends, as appropriate. Ensure information for carers, families and friends provided is accessible across the organisation and interagency system.

			successful relationships are addressed with skill.	
xv. **Understanding and influencing the context of learning disability services** *PCF domains 5 - Knowledge; and 6 – Critical Reflection and Analysis; and 7 – Skills and Interventions*	Develop an understanding of the local policy and provision for adults who have learning disability. Understand how this links to national policy and the impact upon individuals. Begin to develop relationships with other professionals and agencies to increase understanding and identify role in multi-professional and multi-agency contexts.	Understand how national policy drivers affect the configuration of local services – for example austerity and increased emphasis on 'personalisation'. Enhance multi-agency working skills through critical reflection and CPD activities. Critically reflect on how organisational contexts impact on their roles – for instance the differences between being a social worker in the Private, Voluntary and Independent sector and local authority or the NHS.	Develop working relationships with allied professionals and overcome barriers to multi agency working. Share and model good practice with social workers and others. Promote and deliver multi agency professional development and support for critical reflection around organisational contexts and the impact upon people with lived experience, their carers, families and friends, and their experiences and outcomes.	Lead the development of appropriate organisational and interagency structures and partnerships to uphold social work values and ethics in working with adults who have learning disability. Lead the development of policy and strategic advocacy for people with lived experience that recognises and addresses contextual constraints and hindrances to quality, good practice and good experience e.g. inadequate funding, poor commissioning and lack of focus on social work values and the social model.
xvi. **Being accountable** *PCF Domains 1 – Professionalism and 8 – Contexts and Organisations of the PCF*	Develop skills in accessing and participating fully in supervision. Develop further understanding of the ethical and statutory responsibilities in the social work role in the	Seek and prepare for regular practice supervision. Understand how the organisational and professional contexts affect their role and statutory duties. Engage in critical reflection to understand the power	Provide supervision that enables social workers to be open, be accountable, take responsibility and learn, recognising the relationship between individual professional expectations and contextual/systemic constraints and enablers	Continuously evaluate service provision and ensure changes are co-produced with adults who have learning disabilities. Offer leadership and accountability for social work practice with adults who have learning disabilities, promoting a learning culture,

	context of supporting adults with learning disability, their carers, families and friends. Seek, discuss in supervision and act upon feedback from people with learning disabilities, carers, families and friends about their experience of the working relationship and social work practice Seek feedback from other agencies and other professionals.	inherent in their role and how this can be deployed alongside people to empower them.	influencing outcomes and experiences. Engage in critical reflection to explore accountability and issues of power at an individual, team and organisational level. Develop and implement routine systems to gather feedback about practice from people with learning disabilities, their cares, families and friends, other agencies and professionals, to inform continuous improvement, accountability and prompt action.	organisational and inter-agency competence and commitment to the highest quality. Ensure strategic systems are in place and fit for purpose to gather feedback – complaints and compliments - to inform learning, improvement, responsiveness and accountability to people with lived experience and all stakeholders.
xvii. Taking responsibility for self-care and continuous learning *PCF Domains 1 – Professionalism, 8 – Contexts and Organisations and 9 – Professional Leadership*	Develop skills in utilising supervision and critical reflection to identify gaps in learning. Use self-reflection to recognise and act upon presenting stressors.	Honestly and regularly appraise their capabilities and identify gaps they need to address. Plan their CPD regularly, considering their preferred learning styles and exploring opportunities to experience different forms and sources of learning, professional and personal development.	Model good practice to social workers through demonstrating good self-management and self-care skills and commitment to continuous learning. Develop a culture to nurture and develop these skills in others. Ensure mechanisms for asking for support are well known, easy to use and will not	Value and promote the importance of self-management, self-care skills and access to continuous development at all levels of the organisation and/or interagency system. Ensure organisational, HR and management culture and systems respond positively to social workers expressing need for self-care and continuous learning.

		In supervision and other appropriate forums, identify the work situations that cause stress and explore how these can be addressed.	prejudice the person asking for help. Help to ensure social workers understand their rights as professionals and workers and the duties of their employers.	Model good self-care, self-management and continuous learning in own leadership practice.
xviii. Professional leadership	Identify professional leadership development needs and challenges in context of learning disability practice. Develop more confidence to pursue and promote good social work practice in learning disability services.	Identify professional leadership learning needs and plan CPD opportunities to address these. Identify the particular challenges and opportunities for practice leadership and influence within the learning disability sector. Develop collective leadership and networking for peer support and to increase influence to resolve complex issues within organisations and systems.	Develop leadership of practice through undertaking supervisory, educational and/or other evidence-informed, expertise-sharing and influencing roles with social workers and others. Demonstrate effective leadership in developing and upholding high standards of practice and pursuing better outcomes for people with learning disability, the carers, families and friends. Demonstrate leadership rooted in the purpose of social work: its values and ethics and commitment to equality, diversity, rights, social justice and economic wellbeing.	Develop and demonstrate effective strategic and systems-level leadership to improve services, outcomes and experiences of people with learning disability, their carers, families and friends. Develop and demonstrate ability to use and develop the evidence base for good social work within leadership practice and decisions. Develop and demonstrate ability to influence multi-professional and interagency systems of care and support.

www.basw.co.uk

A LEARNING AND IMPROVEMENT STRATEGY

FOR

SOCIAL WORKERS

AND

SOCIAL CARE WORKERS

2019 - 2027

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

"Rules, standards, regulations and enforcement all have a place in pursuit of quality… but they pale in potential compared to the power of pervasive and constant learning."

"You always have two jobs; you have your job and you have the job of improving your job."

Professor Don Berwick

(A Promise to Learn, a Commitment to Act: Improving Patient Safety in NHS England)

Chief Social Worker's Foreword

Society in Northern Ireland is changing rapidly. We are living for longer and communities are now much more diverse than ever before.

Developing new models of care and creating co-operation between formal and informal care providers is an important opportunity to be grasped. Having a dynamic, highly skilled and well-motivated workforce that can innovate and adapt to new ways of working will also be essential.

Delivering Together-Health and Wellbeing 2026 sets the future direction for health and social care by identifying how to meet our existing and emerging needs. The social work and social care workforce is central to achieving its vision of person-centred, compassionate care delivered in communities, with and for service users, families and carers.

The learning and improvement of social workers and social care workers has, for many years, been a key strategic objective for the Department of Health in Northern Ireland.

This **Learning and Improvement Strategy** builds upon that commitment and plots a course for the future development of the social work and social care workforce.

By creating a learning culture in which staff are expected to continuously improve their practice to better meet people's needs, we will establish safer, more sustainable services in the coming years.

I commend the Strategy to you as an important contribution to delivering the changes we need to make, to meet our future social care needs.

Sean Holland
Chief Social Work Officer

Developing the Learning & Improvement Strategy

This is the fourth strategy to be produced in relation to the training and development of the social work and social care workforce in Northern Ireland. It follows-on from the Personal Social Services Training and Development Strategy 2006-16, which was successfully implemented through the concerted efforts of a wide range of individuals and organisations

The implementation of the previous strategy resulted in several notable achievements, including;

- an increase in the number of qualifications achieved by social workers and social care workers,
- significant improvements in the professional leadership and management of social work and social care services. and;
- the development of more flexible approaches to learning.

Above all, the previous strategy, alongside other important developments, created the expectation among social workers, social care workers and their employers that they must continuously develop their knowledge and skills in order to improve outcomes for people who use services, their carers and communities.

This new Learning and Improvement Strategy builds upon those successes and is intended to set the direction for the future development of the social work and social care workforces.

It has been informed by extensive engagement with a wide range of stakeholders who have provided very helpful input. Early planning meetings with key individuals in the sector and responses to consultations on the draft Strategy have contributed greatly to its' contents.

Who is responsible for the Learning and Improvement of Social Workers and Social Care Workers?

A wide range of individuals and organisations share responsibility for the continuous development of social workers and social care workers.

Employers have the primary responsibility to ensure that staff have the knowledge and skills they need to competently fulfill their role and function.

Social workers and **social care workers** must also seek to improve and add to their skills set, which is a requirement of continued registration with the Northern Ireland Social Care Council. Individual practitioners and teams should **want to** continuously improve their own practice, learn new methods, and demonstrate professional pride in what they do.

All learning and improvement activity should contribute to better outcomes for people who use services, their families and carers.

The Strategic Context

The Learning & Improvement Strategy has been developed within a much wider strategic context. The projected growth of the Northern Ireland economy is likely to be modest for the foreseeable future, meaning that there will be a continued emphasis on budgetary constraint and achieving best value for money.

The impact of austerity measures will continue to be felt across NI, but most acutely in areas of high deprivation. As a consequence, the demands on public services, including social services, are expected to increase substantially in the coming years.

Northern Ireland has also experienced rapidly-changing racial, ethnic and cultural trends in recent years. The size of the total population is set to grow by around 6% by 2020, and the proportion of people aged 65 years and over will increase by 45% by 2030.

More people are living for longer and as a result, many of us will have long-term health and social care needs. How we deliver and receive our health and social care services will therefore have to fundamentally change in order to meet these growing, more challenging demands.

As part of the response to these changes, it will be necessary to build capacity in individuals, in families and in communities, to reduce inequalities and ensure the next generation is encouraged to stay healthy and well.

Health and Wellbeing 2026 'Delivering Together' (DoH 2016), sets the future direction for Health and Social Care in NI by identifying the importance of;

- supporting people to avoid ill-health and stay well in the first place,
- providing access to safe, high quality care when it is needed,
- empowering and supporting health and social care staff to perform their roles to the best of their ability, and
- designing services which are efficient and sustainable.

Alongside societal changes, the Learning & Improvement Strategy must also be informed by and complement existing legislation, policy and strategies – and take account of new and emerging ones.

For example, the Strategy for Social Work, Quality 2020, Making Life Better, A Whole System Framework of Public Health, Power to People, the HSC Collective Leadership strategy, and the Industrial Strategy for NI will all contribute to efforts to ensure that we have a competent and confident health and social care workforce in the future

The Aim of the Learning and Improvement Strategy for Social Workers and Social Care Workers is;

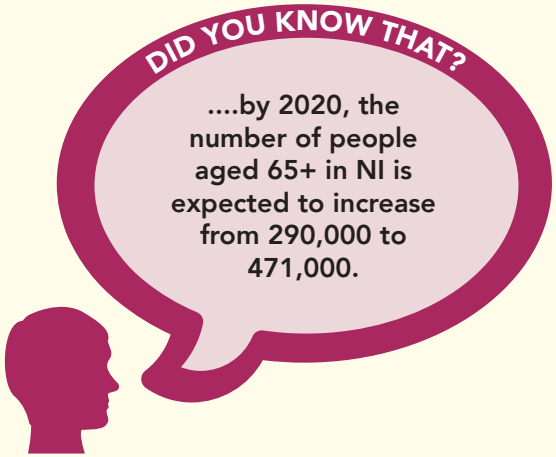
To set the strategic direction for learning and improvement,

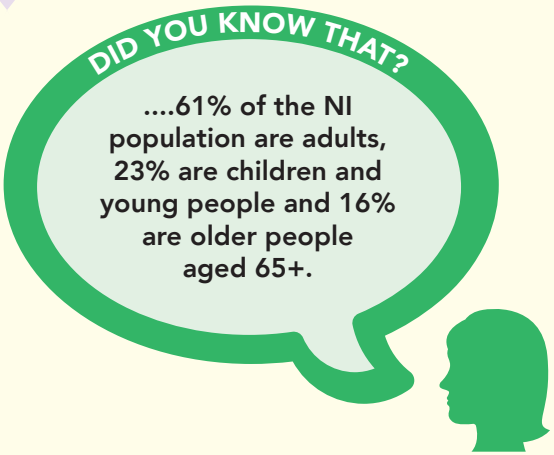
which will be required to develop and maintain the knowledge, skills, competence and confidence,

to deliver safe, effective and efficient care,

leading to

improved outcomes for people who use services, carers and communities.





The Social Work Workforce

Social workers often work with some of the most marginalised people in society, by promoting their rights, challenging inequalities and improving the quality of their lives. Social workers share a common purpose, which is to improve and safeguard the social wellbeing of individuals, families and communities.

Improving Social Wellbeing

Social wellbeing is a broad concept and applies to many areas in a person's life – for example, how someone feels about themselves, the quality of the relationships they have with others, or the freedom they have to make important decisions which impact on their daily lives.

Social workers improve social wellbeing by empowering people to manage their own lives, by supporting social inclusion and participation in society, and helping people to stay safe and well.

Central to the effectiveness of all social work practice is the quality of the relationships between a social worker and the people they work with.

The Social Work Practice Continuum summarizes the range of functions which social workers typically fulfil, depending upon their job role. It reflects the diversity of life circumstances and needs of individuals, families and communities with which social workers work.

Social work practice is also underpinned by a core set of **professional values**;

Social Work - interesting Facts and Figures

There have been significant changes in the social work workforce in Northern Ireland in recent years. The number of registered social workers has risen substantially from **5,060** in 2007 to **6,100** in 2018, which represents a **17% increase**.

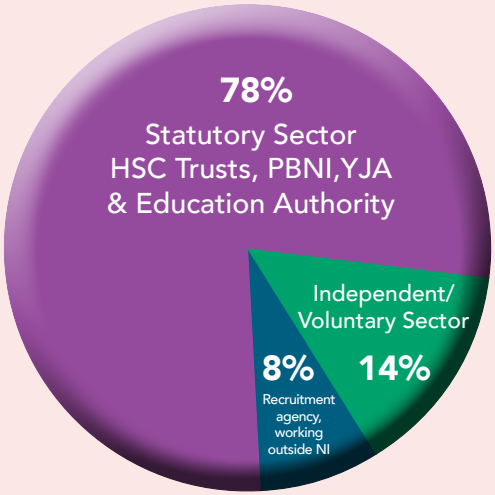
The majority of social workers, around **70%**, are employed within the Health and Social Care sector; in family and child care settings, in adult services, hospitals, mental health teams and helping people with a learning disability.

Social workers also work in many different settings and contexts. Within statutory agencies, such as HSC Trusts, Probation or the Education Authority, social workers typically carry out tasks related to legal or statutory requirements.

In total, around **80%** of all social workers are employed in the statutory sector. This often involves working collaboratively with a range of other public services such as the police, health professionals or housing providers.

Northern Ireland also has a rich history of many social work services being delivered by the voluntary and community sectors, often in collaboration with colleagues from statutory services.

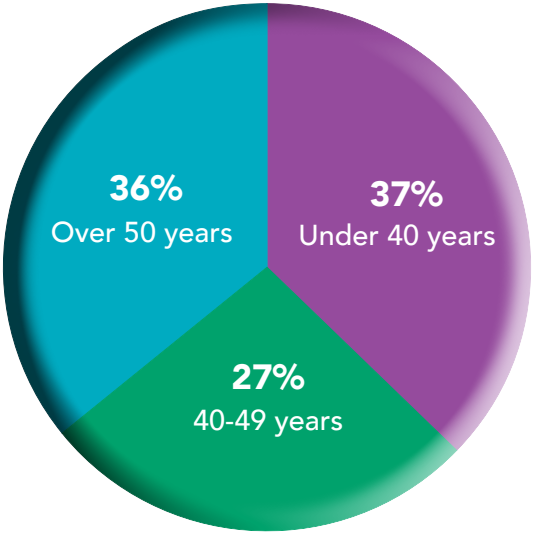
Who employs social workers?
The pie chart below provides details of the sectors in which social workers are currently employed;



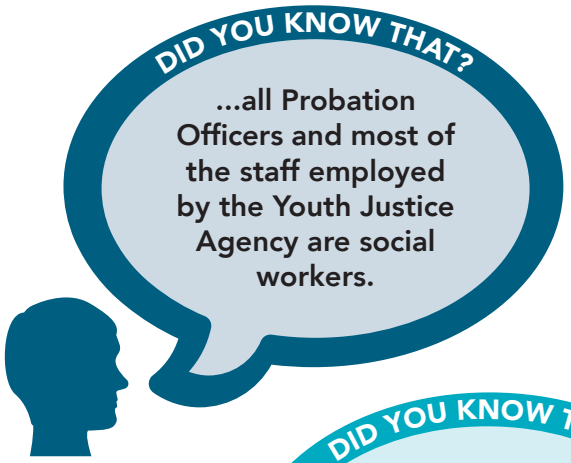
17% increase
in registered social workers
from 2007 to 2018

Age and Gender of Social Workers

The profile of the social work profession in Northern Ireland is one of a mature, predominantly female (81%) and locally trained workforce which has remained relatively stable over the last ten years. Approximately 250 social workers graduate from Queen's University Belfast and Ulster University each year.



The majority (63%) of registered social workers are over 40 years of age and around one third (36%) are aged 50+. The majority of social workers employed locally are originally from NI and most have received their professional training at Universities here.



The Social Care Workforce

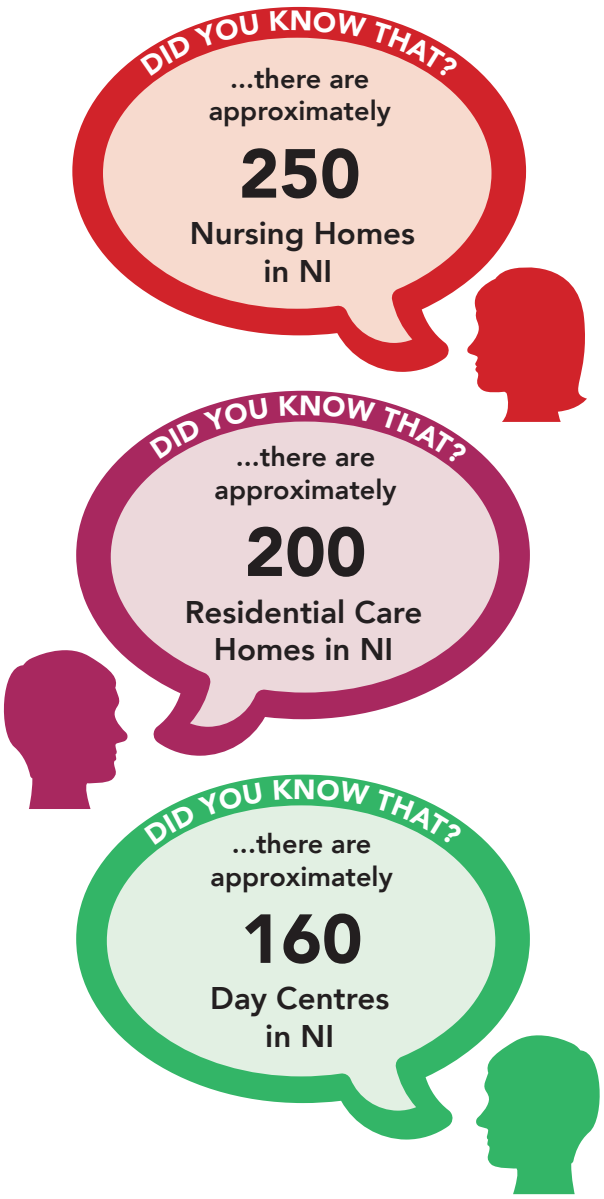
Social care workers help to support, protect and empower people to live as well and as independently as possible. They often deliver a range of practical help and emotional support to individuals, families and communities.

Typically, social care workers provide;

- personal care for individuals who have particular needs associated with ill-health, disability, frailty or aging,
- care for people in day care settings, domiciliary care or reablement services,
- more intensive support, in residential homes or delivering complex home-care packages; and
- informal community support, for example, befriending services or engaging with community groups.

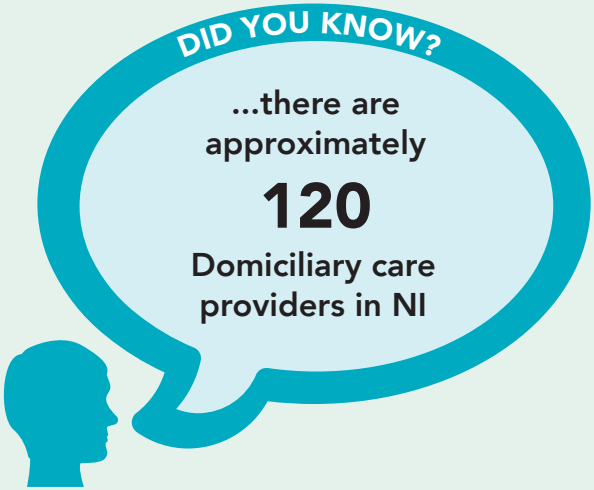
People who work in social care often come from diverse backgrounds. The level of competence or type of qualification required to be a social care worker is determined by the role or job function, the nature of the care and support required by the individual or family, and the level of responsibility vested in the worker.

To become a social care worker, a number of employer criteria and regulatory requirements have to be met. The values, skills and personal qualities demonstrated by staff are key to the delivery of safe and effective, person-centred social care.



Meeting individual needs

In recent years there has been a growing emphasis on the personalisation of social care to meet individual needs. There has also been a wider societal expectation that, where possible, a person's social care needs should be met within his or her own home or community. This is intended to give an individual or a family, greater choice and control over the kind of care that they wish to receive. The **Co-production** of services and Self Directed Support continue to be embedded in the suite of social care provision in NI.



Social Care Work - interesting Facts and Figures

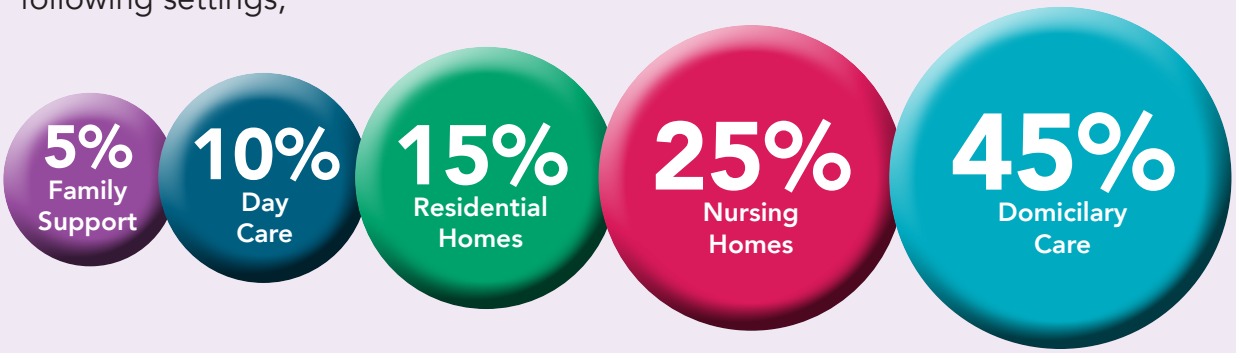
Since 2017, it has been compulsory for all social care workers to register with the Northern Ireland Social Care Council (NISCC) . There are approximately **33,000 registered social care workers**, which is the largest workforce in HSC, and represents 4% of the total workforce in NI.

A majority of social care workers have achieved qualifications which are relevant to their job role and function. All social care workers are expected to improve their knowledge and skills as a requirement of their continued registration with the NISCC.

There are approximately 900 registered providers of social care services in Northern Ireland. One quarter of the social care workforce is employed directly by the HSC Trusts. The majority (75%) of social care workers are employed in independent, private and voluntary sector organisations.

Where do social care workers work?

Social care workers are typically employed in one or more of the following settings;



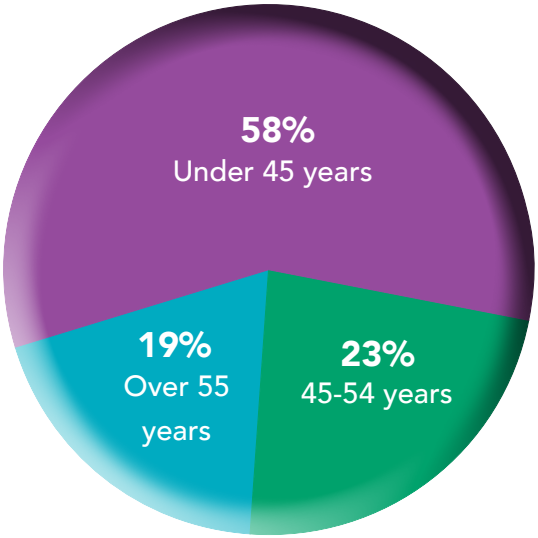
Age and Gender of Social Care Workers

The profile of the social care workforce in NI is very different to that of social workers. As well as the difference in the size of the workforce, almost 19,800 (58%) of social care workers are under 45 years of age.

The social care workforce is also predominantly female (87%) and includes people from a wide range of cultural and ethnic backgrounds.

For some time, employers have reported difficulties with the recruitment and retention of social care workers. This is a particular problem in rural areas and in the private and voluntary sectors where there can be less favourable terms and conditions of employment.

The co-ordination and implementation of key workforce policies, including those relating to learning and improvement, will help to determine the future recruitment and retention of suitably qualified and highly motivated social care workers.



Registration, Regulation and Standards of Practice

The Northern Ireland Social Care Council (NISCC) is responsible for approving the professional training for social workers, against a set of regional standards, and for approving post qualification training and learning provision. To maintain their registration with the NISCC, social workers are required to complete and record at least 90 hours of professional development every three years.

Social workers can accumulate Professional in Practice credits for learning achieved through a variety of routes, including formal training events, individual study and academic courses.

All social care workers in Northern Ireland are now registered with the NISCC. To maintain their registration, social care workers must also demonstrate that they have undertaken the requisite learning and improvement activity as prescribed by the NISCC. It is estimated that at present more than half of social care workers have one or more qualification which is relevant to their job role.

Employers of social workers and social care workers are expected to ensure that their staff are appropriately trained to competently fulfil the duties of their job role. This includes mandatory training courses and adherence to relevant minimum standards, which is monitored by the Regulation and Quality Improvement Authority.

The NISCC is also required to publish Standards of Conduct and Practice for social workers and social care workers. These provide clear criteria to guide practice and ensure that social workers and social care workers are aware of the standards they are expected to meet. The Standards also provide service users and carers with a clear description of the nature and quality of care they can expect to receive.

To achieve the Aim of the Learning and Improvement Strategy, we have identified **six Strategic Priorities**;

1. **Relationship-based Practice**
2. **Highly Skilled, Resilient and Confident Workforce**
3. **Continuous Learning and Improvement**
4. **Effective Leadership and Management**
5. **Collaboration and Partnership**
6. **Practising in a Digital World**

Each Strategic Priority has a series of associated Policy Statements and Actions which, if completed, will contribute to the achievement of identified Outcomes. An initial Implementation Plan will be developed to help to ensure that the Strategy receives the support needed to secure the delivery of the Strategic Priorities.

As before, the energy and commitment of the various stakeholders will be required to ensure that the Learning and Improvement Strategy is successfully implemented in the coming years.

Strategic Priority 1:

Relationship-based Practice

Social work and social care work is about relationships – first and foremost with people who use services and their carers. The ability to build purposeful and trusting relationships to create positive change is the cornerstone of best practice.

Social workers and social care workers engage with individuals, families, carers, communities and other professions in a concerted effort to produce better outcomes for and with people.

A co-production approach to improving social wellbeing is a collaborative process between the person supported by services and those who support them. It allows all parties to work together to determine an outcome that draws on someone's strengths and assets, their knowledge, skills and abilities and those of a wider support network.

Tackling inequalities and promoting social justice using community development approaches can also enhance social work and social care practice by empowering and bringing about positive changes in the lives of individuals and in communities. It encourages people to take personal and collective responsibility and helps them to organise and work together to improve their own and others' health and wellbeing.

Policy Statements

1. A relationship-based approach will be an integral part of social workers' and social care workers' practice.

2. Social workers and social care workers will be supported to develop and maintain the values and skills they need to enable and empower individuals, families, carers and communities to improve their social wellbeing.

3. Co-production and use of strengths-based and community development approaches will be promoted as a means of building upon people's capacity to manage their own lives and bring about positive change.

Strategic Actions

1. Education and training providers will ensure that there is a strong emphasis on relationship-based practice and co-production, in professional and vocational training for social workers and social care workers.

2. Learning and improvement activity will increase social workers' and social care workers' capacity to use strengths-based and community development approaches to their practice.

3. Service users and carers will be encouraged and helped to co-produce learning and improvement activity for social workers and social care workers.

LEADING TO

Outcomes

- ✓ A relationship-based approach, based on empathy, reliability and respect will be integral to social workers' and social care workers' practice.
- ✓ There will be evidence of the increased use of strengths-based and community development approaches in social work and social care services.
- ✓ People who use services, their families and carers will be more directly involved in decision making regarding the design and delivery of the care they receive.
- ✓ The knowledge, skills, expertise and experience of service users, their families and communities will help to shape and inform the development of future social work/social care training, policy and practice.

Strategic Priority 2:

Highly Skilled, Resilient and Confident Workforce

Social workers and social care workers play a crucial role in improving and safeguarding the wellbeing of people who use services. Ways of working are changing but values and principles will remain constant. Services of the future will be increasingly dynamic, flexible and responsive and build upon individual, family and community supports.

Social workers and social care workers will need the energy, confidence and resilience to adapt to continuous change. Learning and improvement activity must focus on developing the knowledge and skills required to provide safe and effective care, which improves the lives of those people who use services.

Policy Statements

1. Social workers and social care workers will be skilled, resilient and responsive, and demonstrate enthusiasm, confidence and competence in their practice, whilst upholding highest professional standards.

2. Social workers, social care workers and employers are responsible for developing and maintaining the knowledge and skills needed to be safe, effective and caring practitioners.

3. Social workers and social care workers will be supported to achieve qualifications which are relevant to their job role and function.

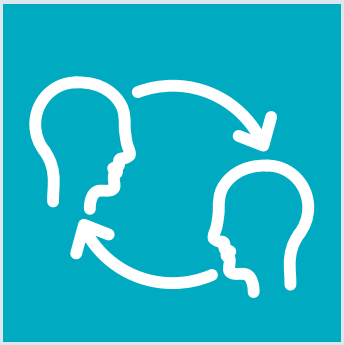
Strategic Actions

1. An audit of qualification achievement in the social work and social care workforce in HSC will be conducted and appropriate targets set for future attainment.
2. The commissioning and provision of learning and development opportunities for social workers and social care workers will be reviewed to ensure that it is fit for purpose.
3. A Framework for Career Progression for social workers will be developed, which will link to the achievement of qualifications and/or learning criteria.
4. A Learning and Improvement Framework for social care workers will be developed which will be in keeping with the strategic direction for future social care provision.

LEADING TO

Outcomes

- ✓ Social workers and social care workers will be supported in applying and sustaining core knowledge and skills into practice, and in the achievement of more specialist expertise and/or qualifications as their careers progress.
- ✓ There will be a more strategic and co-ordinated approach to the commissioning and delivery of learning and improvement opportunities for social workers and social care workers employed in the HSC sector.
- ✓ Learning and improvement activity will focus on developing the knowledge and skills that are essential to the delivery of safe and effective care, leading to improved outcomes for people who use services, their families and carers.
- ✓ There will be an increase in the achievement of qualifications for social workers and social care workers in NI.



Strategic Priority 3:

Continuous Learning and Improvement

A culture of continuous learning and improvement within any organisation is as important as rules, standards and control strategies in the pursuit of higher quality outputs. Organisations which employ social workers and social care workers must be committed to creating learning communities, in which staff are supported to be professionally curious, share information and expertise, are open-minded and want to do even better.

The workplace should be exploited as a rich field of learning in which individuals can learn from their own experience, from each other and from planned and unplanned learning opportunities. All staff should be able to identify how any learning activity relates to their job function, and understand how acquiring new knowledge, skills and qualifications will help their employer to better meet the needs of those people who use services.

To ensure the effective transfer of learning to improving practice, new and more meaningful measures for evaluating the benefits of staff learning and development activity will be required.

Policy Statements

1. Employers will encourage and support social workers and social care workers to engage in the continuous development and improvement of their practice throughout their careers

2. Social workers and social care workers will be equipped to contribute to continuously improving practice and service provision, in partnership with people who use services.

3. Learning and improvement activity will be expected to deliver better outcomes for those people who use services, and agreed criteria will be developed to assess its impact on improving practice.

Strategic Actions

1. Social work and social care employers will encourage and develop a culture of continuous learning and improvement at individual, team and organisational levels.
2. The knowledge-base for effective social work and social care practice in NI will be built upon and supported by evidence and validated research.
3. The impact of learning and improvement activity will be evaluated to determine the extent to which it improves practice and leads to better outcomes for people who use services.
4. Social workers and social care workers will build their capacity to lead and contribute to continuous improvement, in partnership with people who use services and their families.

LEADING TO

Outcomes

- ✓ A learning culture will be evident at team, organisational and regional levels in social work and social care organisations, where staff experience a commitment to "help to learn" throughout their career.
- ✓ Social workers' and social care workers' practice will be evidence-based, underpinned by up to date research and they will be aware of the most effective ways of working within their chosen practice field.
- ✓ New methods will be designed to measure the quality of learning and development practice and its impact upon improving social wellbeing.
- ✓ Social workers and social care workers will demonstrate an expertise in measuring the outcomes and experiences of people who use services, their carers and wider support networks.

Strategic Priority 4:

Effective Leadership and Management

High quality, safe and effective services, and the drive for continuous improvement in organisations comes from what leaders do – through their vision, commitment and modelling of appropriate behaviours. The best leaders and managers support and empower their staff by cultivating a positive organisational climate, promoting staff health and wellbeing and inspiring innovation and change.

Social work and social care services of the future will require leaders and managers at all levels, who involve staff and people who use services in decision making, provide regular helpful feedback, and recognise achievement and excellence. They address systems problems as they arise and ensure that staff feel supported, respected, empowered and valued at work.

Leaders and managers should also engage in activities which promote a higher, positive public profile for social work and social care, leading to a better understanding of its unique contribution to improving and safeguarding the wellbeing of society.

Policy Statements

1. Leaders and managers of social workers and social care workers at all levels will be equipped with the skills they need to provide professional leadership and management, coaching, and the development of others.

2. Leaders and managers will work collectively to appropriately influence relevant policy and strategy and the future development of social work and social care.

3. The future leaders of social work and social care organisations will be nurtured, encouraged and assisted to develop the knowledge and skills they require.

Strategic Actions

1. Leaders and managers at all levels in social work and social care organisations will engage in a range of learning and improvement opportunities aimed at enhancing their leadership capabilities.

2. Leaders and managers will adopt a collective leadership approach to ensuring the development and future strategic direction of social work and social care.

3. Social work and social care providers will be responsible for ensuring that their staff have the knowledge, skills and expertise they need to deliver safe and effective care.

LEADING TO

Outcomes

✓ Social work and social care organisations will have strong leaders and managers who drive safe and effective practice and are committed to securing the best possible outcomes for people who use services.

✓ Leaders and managers will work collegiately to influence policy, to set strategic direction and to promote social work and social care within a wider professional, political and economic context.

✓ The leaders of social work and social care organisations will nurture and maintain an ambitious and creative organisational culture which is focussed on learning and continuous improvement.

✓ Opportunities will be made available for future managers of social work and social care to gain the expertise and experience they will require to be the most effective leaders of tomorrow.

Strategic Priority 5:

Collaboration and Partnership Working

Collaboration and partnership working is key to improving and safeguarding social wellbeing. Social workers and social care workers must be able to participate fully in existing partnerships, forge new and effective relationships with colleagues and be confident of their role and function within multi-disciplinary teams.

Social workers and social care workers should continue to develop and enhance their skills in collaborative and multi-disciplinary working.

Effective partnerships in the provision of learning and improvement also offer the best opportunity for achieving higher standards and securing regional consistency. The partnerships in place between social work and social care employers, Further/Higher Education providers and service users, also help to ensure that professional and vocational training courses are of the highest quality and keep pace with changing needs.

Policy Statements

1. Social workers and social care workers will have the confidence and skills to be effective and respected practitioners who can clearly articulate their role and function, and their contribution to improving and safeguarding social wellbeing will be understood and valued.

2. Social workers and social care workers will actively participate in multi-disciplinary and inter-professional teams, leading to a sharing of experience and expertise and better outcomes for people who use services.

3. The partnerships in place between employers, education providers and service users will be maintained and strengthened in order to maximise the availability of high quality learning opportunities for social workers and social care workers.

Strategic Actions

1. Social workers and social care workers will be supported to acquire the skills they need to work in multidisciplinary teams, with colleagues from other professions and across different sectors.

2. Key stakeholders, including employers, providers, the NISCC and relevant Government Departments, will work together to maximise the availability of high quality learning opportunities for social workers and social care workers.

3. Partnership arrangements between employers, service users and education providers will be strengthened, to ensure that professional and vocational training courses reflect the changing needs of social workers, social care workers and people who use services.

4. Where appropriate, training and development opportunities for social workers and social care workers will be delivered on a partnership basis to facilitate the sharing of best practice, regional consistency and to make the best use of scarce resources.

LEADING TO

Outcomes

✓ Social workers and social care workers will have a clear understanding of their roles and functions within multi-disciplinary settings and be confident of their unique contribution to improving the wellbeing of people who use services.

✓ More effective working relationships will be evident between social workers, social care workers and colleagues from other disciplines and professions, in multidisciplinary and interprofessional teams and across different sectors.

✓ There will be a better co-ordination of effort and expertise between the relevant stakeholders in the provision of learning opportunities for the social work and social care workforce.

✓ Learning and development activity within social work and social care organisations will be strengthened and improved.

Strategic Priority 6:

Practising in a Digital World

Working practices are changing, and social workers and social care workers are expected to use up-to-date assistive technology to help them to provide the most effective and efficient services.

Greater diversity in the workforce and more flexible working arrangements also mean that new approaches to learning and development will be required. In the future, there will be particular emphasis on improved e-learning methodology, which can allow information to be delivered in different ways, at different times and places, and at a pace which matches individual learning styles.

Digital technology already provides a range of innovative approaches to gaining knowledge and skills. A mixture of e-learning, face-to-face training and work-based experience provides a wider range of improvement opportunities. This 'blended approach' makes it possible to maximise the opportunities to apply new learning to practice, leading to improved outcomes for people who use services, families and communities.

Policy Statements

1. Social workers and social care workers will be equipped with the skills they need to make best use of technological advances, leading to more effective and efficient services.

2. Learning and improvement approaches which involve the use of new technology will be accessible, flexible and provide good value for money.

3. Social workers and social care workers will have the knowledge and skills they need to better understand and manage the risks associated with the use of technology in the workplace, and to help to maintain the safety of people who use services within a complex digital world.

Strategic Actions

1. Social workers and social care workers will become skilled in the use of existing and emerging technology which is aimed at improving outcomes for people who use services.

2. A range of methods to facilitate staff training, which includes high quality e-learning packages, face-to-face training and work-based mentoring, will be developed and made available.

3. Employers will ensure that social workers and social care workers have the knowledge and skills they need to make best use of modern technology to enhance and improve services; that they use it responsibly and help to safeguard people who use services from any associated harm.

LEADING TO

Outcomes

✓ Social workers and social care workers will use the most effective and up-to-date methods, including appropriate technological advances, which are designed to support working practices and enhance the services they deliver.

✓ Access to learning opportunities for the workforce will be improved by being more flexible and available at different times and places, to best suit learners' needs.

✓ Using blended-learning approaches to training and improvement activity, social workers and social care workers will maximise the opportunities to transfer newly-acquired knowledge and skills to the workplace.

✓ Social workers and social care workers will act responsibly in their use of technology, to improve practice in the delivery of efficient and effective services while assisting people who use services to maintain their safety and wellbeing.

Setting the direction for the future development of the social work and social care workforce.






Design: conordiverdesign.com

For further information please contact:

Office of Social Services
Department of Health
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
OSS@health-ni.gov.uk

Office of Social Services

Improving and Safeguarding Social Wellbeing in Northern Ireland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

3.015

Belfast Health and Social Care Trust

REFERENCE NUMBER	SG 057/09
	Professional Social Work Corporate Supervision Policy
Summary	This policy provides a template for the development and operation aligning of discrete Service Area professional supervision procedures for Trust social work staff.
Supercedes	
Operational date	*October 2009*
Review date	*October 2011*
Version Number	
Director Responsible	Ms Bernie McNally
Lead Author	Mr John Growcott
Lead Author, Position	Co-Director Social Work/Social Care Governance
Department / Service Group	Departmental/Service Group: Social Services
Contact details	[redacted]
Additional Author(s)	

Date	Version	Author	Comments
Sept 09	0.1	John Growcott	Draft

Policy Record

		Date	Version
Author (s)	Approval	Sept 09	V0.1
Director Responsible	Approval	Sept 09	V1

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval	16/12/2009	V1
Policy Committee	Ratify	18/01/2010	V1
Executive Team	Authorise	20/01/2010	V1
Appropriate Director	Sign Off	23/01/2010	V1

Local Approval Process

	Approval		

Dissemination

Areas :	

Full Description

Title: Professional Social Work Corporate Supervision Policy

1. Introduction:

This policy seeks to provide a corporate template for the development and operation aligning of discrete Service Area professional social work supervision procedures which reflect the particular operational, logistical and professional considerations underpinning service delivery within the individual Service Areas and meet the standards detailed in the Scheme for the Delegation of Statutory Functions (March 2008) .

2. Purpose:

The policy outlines a corporate template and related standards for the implementation of Service Area professional supervision procedures for professional social work staff.

The term "professional social work staff" relates to those Trust staff who are registered on the Social Work Part of the NISCC Register.

Professional supervision is an important mechanism for ensuring: the delivery of safe and effective services to users; the appropriate discharge of the Trust's Statutory Functions; the development of staff members' competencies and skills; and the promotion of staff members' full participation in the organisation.

Professional supervision should be integrated with and contribute to line management supervision processes, the Trust's Personal Contribution Planning and Personal Development Review framework (PCP/PDF), Knowledge and Skills (KSF) reviews and should contribute to the evidencing of the Northern Ireland Social Care Council's (NISCC) post-registration Post Registration Training and Learning (PRTL) requirements.

3. The Scope:

This Policy informs the supervision procedures for professional social work staff in all service settings across the Trust.

4. Objectives:

- To detail the elements to be included in each Service Area's professional social work supervision procedures.
- To identify the core standards informing the provision of professional supervision to social work staff across all Trust service settings.
-

5. Roles and Responsibilities:

The Service Area procedures should specify the roles and responsibilities of both supervisor and supervisee and link the procedures with line management supervision, the PCP/PDF and KSF frameworks and PRTL processes.

6. The definition and background of the policy:

Professional supervision is a process as opposed to an event. It facilitates the identification and review of individual performance in relation to the attainment of organisational objectives, personal and professional development and the effectiveness of an individual's organisational engagement.

7. Policy statements:

7.1Principles

- Professional supervision should promote the effective management of staff, enhance staff's engagement with the organisation and develop their competencies and skills base.
- All staff have a responsibility for the quality of their own work and, to this end, should prepare for and contribute to the professional supervisory process.
- Senior Management has a responsibility to promote the development of qualitative professional supervisory practice and to facilitate appropriate training in the delivery of and participation in supervision for all social work staff.
- All social work staff should have access to regular professional supervision in line with the standards detailed in the Scheme for Delegation of Statutory Functions.
- The professional supervision process for social work staff should be fully integrated with and complement line management supervisory, KSF and PCF/PDF processes and should contribute to the evidencing of the NISCC's PRTL requirements.
- Service Area social work professional supervision procedures should be consistent with the standards detailed in the NISCC Code of Conduct for Employees and Employers.

7.2 Methods

Professional supervision can involve a number of models: one-to-one supervision where one worker is given responsibility to work with another to meet certain organisational, professional and personal objectives; group supervision; team supervision; and mentoring by Senior or Principal Practitioner staff.

Whichever model is used, essential pre-requisites are that the needs of the individual staff member and organisational objectives are appropriately identified, addressed and recorded.

7.3 Functions of Professional Supervision

The key functions of professional supervision are:

Performance: Ensuring competent and accountable performance.

The professional supervisor may or may not have a line management role with the supervisee.

In those circumstances in which the professional supervisor exercises such a remit, a central dimension of the supervision process will be to address direct service delivery issues and related performance within a focus on professional competence and personal development.

In those situations in which the professional supervisor does not have a direct line management role with the supervisee, the focus on performance will be primarily contextualised within a professional competency and related standards focus in which the supervisee and supervisor will primarily consider practice effectiveness and professional learning and development needs linked to organisational remit.

Induction and Development: Addressing the supervisee's organisational and professional induction to identify and promote opportunities for continuous , professional development and training needs linked to the NISCC's re-registration requirements, the Trust's appraisal and individual learning and development processes.

Support: The provision of guidance and support across professional, organisational and, where appropriate, personal areas.

Engagement with the Organisation: Building on induction to ensure that the individual supervisee has ongoing opportunities to fully participate in and contribute to organisational processes.

7.4 Standards

- All staff should be provided with regular and formal professional supervision. In those circumstances in which staff are line-managed by an individual who is not a registered social worker, individual professional supervision should be available to the staff member on at least a quarterly basis.
- Professional supervision should be planned and facilitate an opportunity for reflection and discussion.
- All professional supervision arrangements should be contextualised within a written contract between supervisor and supervisee which is drawn up within the first six weeks of the commencement of the supervisory relationship.
- All professional supervision sessions are recorded with copies signed and retained by both the supervisee and supervisor. A copy of the minutes of each professional supervision session is to be retained in the supervisee's professional supervision file.

- Line Management supervision arrangements should comply with the Trust's policy in relation to same.
- Tri-partite meetings between the supervisee, line manager and professional supervisor should be held on at least an annual basis to review the supervisee's overall progress and development, to identify areas and related goals in which the supervisee would benefit from specific training and practice opportunities and to establish an agreed plan with named responsibility for any actions for the achievement of same to be reviewed at the next tri-partite meeting.
- The individual tri-partite meetings should be minuted and signed by all parties with a copy retained in the supervisee's professional supervision file.
- Supervision arrangements in relation to those staff completing the Assessed Year in Practice (AYE) should comply with the standards detailed in the Trust's AYE Guidelines.

8. Audit

In line with the Trust's overarching Assurance Framework, each Service Area Professional Social Work Supervision Procedures should reference requirements in relation to self-assessment and audit.

Director
Printed name Bernie McNally

Author
Printed Name John Growcott

3.016

Belfast Health and Social Care Trust

Reference No: S+G 57/09

Title:	CORPORATE PROFESSIONAL SUPERVISION POLICY FOR SOCIAL WORK STAFF IN ADULT SERVICES		
Author(s)	Mr John Growcott, Co Director Social Work and Social Care		
Ownership:	Bernie Mc Nally / Executive Director of Social Work / Social and Primary Care		
Approval by:	Standards and Guidelines Policy committee	**Approval date:**	24/10/12 19/11/12
Operational Date:	Feb 13	**Next Review:**	Feb 15
Version No.	2	**Supercedes**	All Trust Professional Social Work Supervision Policies V1-Oct 2009-2011
Links to other policies			

Date	Version	Author	Comments
01/10/2009	1	Mr John Growcott	Professional Social Work Corporate Supervision Policy Standards and Guidelines Committee – approved Jan. 2010. Review Date - October 2011.
01/02/2012	1.1	MrJohn Growcott	Review of policy-date change only
24/10/2012	2	MrJohn Growcott	For review in new template

Belfast Health and Social Care Trust

Summary

The Trust Corporate Policy and Procedures provide the framework for the delivery of professional supervision to social work staff engaged in the delivery of Adult services.

The Reform Implementation Team Supervision Policy, Standards and Criteria afford the structure for the provision of supervision to all social work staff involved in the delivery of statutory children's services.

Purpose

The Policy and Procedures seek:

- To identify the core principles underpinning the professional supervisory process for the Trust's social work staff across all Service Areas.
- To detail the key standards which inform the delivery of professional supervision to social work staff in Adult Services.
- To facilitate the Trust's compliance with the requirements referenced in the Northern Ireland Social Care Council's (NISCC) Code of Practice for Employers in relation to supervision.

Reviewed: February 2012

Director Responsible:	**Miss Bernadette McNally, Executive Director of Social Work**
Lead Author:	**Mr John Growcott**
Lead Author Position:	**Co-Director Social Work and Social Care**
Directorate:	**Social and Primary Care**
Contact Details:	**Fairview 1, Mater Hospital Site 90803606**
Reference Number:	**TBC**
Supersedes:	**All Trust Professional Social Work Supervision Policies**

FULL DESCRIPTION

1.0 TITLE

Belfast Health and Social Care Trust Corporate Professional Supervision Policy for Social Work Staff in Adult Services.

2.0 PURPOSE

2.1 This Policy identifies the core principles underpinning the professional supervisory process for the Trust's social work staff across all Adult Services. It outlines the principal standards which inform the delivery of professional supervision to social work staff in Adult Services and facilitates the Trust's compliance with the requirements referenced in the Northern Ireland Social Care Council's (NISCC) Code of Practice for Employers in relation to supervision.

2.2 The term "professional social work staff" relates to those Trust staff who are registered on the Social Work Part of the NISCC Register.

2.3 Professional supervision is a key mechanism for ensuring: the delivery of safe and effective services to users; the appropriate discharge of the Trust's Statutory Functions; the development of staff members' competencies and skills; and the promotion of staff members' full participation in the organisation.

2.4 In those circumstances in which a line manager is not a registered social worker, the professional supervision process should contribute to the Trust's Personal Contribution Planning and Personal Development Review framework (PCP/PDF), Knowledge and Skills (KSF) reviews and the individual supervisee's Post Registration Training and Learning (PRTL) requirements.

3.0 SCOPE

3.1 This Policy provides a framework for the delivery of professional supervision to social work staff engaged in delivering Adult social care services.

4.0 OBJECTIVES

4.1 This Policy has the following objectives:

- To outline of the functions of professional supervision.
- To identify the principles and requisite standards informing the provision of professional supervision to social work staff working in Adult Services.
- To clarify the roles and responsibilities of the supervisor and supervisee in relation to the professional supervision process.

5.0 KNOWLEDGE AND SKILLS FRAMEWORK (KSF)

5.1 All staff in Health and Social Services are required to complete the Knowledge and Skills Framework (KSF) Performance and Development Joint Review on an annual basis.

5.2 The KSF Performance Review provides an opportunity for the staff member to reflect on their knowledge, skills and values in a structured way, focusing on the knowledge and skills required for their job profile. The line manager completes the performance review form at this meeting. Individuals will be assessed on their examples of practice and the supervisee and supervisor will need to identify the most relevant examples in order to meet the requirements.

5.3 In those circumstances in which professional supervision is provided by a registered social worker who is not the operational line manager, the outcomes of the Tri-partite Meeting process (referenced at 10.7) between the supervisee, line manager and professional supervisor should contribute to/inform the KSF Review.

6.0 PERSONAL DEVELOPMENT FRAMEWORK (PDF)

6.1 The Trust's Personal Development Framework (PDF) provides an organisational mechanism for assuring that the individual worker has a Personal Development Plan (PDP)-a formal overview of their specific learning and development needs.

6.2 The professional supervision process is the vehicle for the development and review of the individual social worker's PDP. It is integral to the PDF Framework.

6.3 In those circumstances in which professional supervision is provided by a registered social worker who is not the operational line manager, the outcomes of the Tri-partite Meeting process (referenced at 10.7) between the supervisee, line manager and professional supervisor should contribute to/inform the PDP Plan.

7.0 PRINCIPLES

7.1 Professional supervision should promote the effective management of staff, enhance staff's engagement with the organisation and develop their competencies and skills base. .

7.2 All staff have a responsibility for the quality of their own work and, to this end, should prepare for and contribute to the professional supervisory process.

7.3 Senior Management has a responsibility to promote the development of qualitative professional supervisory practice and to facilitate appropriate training in the delivery of and participation in supervision for social work staff.

7.4 All social work staff should have access to regular professional supervision in line with the standards detailed in the Scheme for the Delegation of Statutory Functions.

7.5 The professional supervision process for social work staff should be fully integrated with and complement line management supervisory, KSF and PDP processes and should contribute to the evidencing of the NISCC's PRTL requirements.

7.6 The Trust's professional social work supervision processes should meet the standards referenced in the NISCC Code of Practice for Employees and Employers in respect of supervision.

7.7 Professional supervision must promote anti-discriminatory practice.

8.0 FUNCTIONS AND PROFESSIONAL SUPERVISION

The key functions of professional supervision are:

8.1 Performance-ensuring competent and accountable performance.

In those circumstances in which the professional supervisor exercises a direct line management remit in respect of a supervisee, a central dimension of the supervision process will be to address direct service delivery issues and related performance within a focus on professional competence and personal development.

In those situations in which the professional supervisor does not have a direct line management role with the supervisee, performance issues will be primarily contextualised within a professional competency and related standards focus in which the supervisee and supervisor will primarily consider practice effectiveness and professional learning and development needs linked to organisational remit.

8.2 Induction and Development-addressing the supervisee's organisational and professional induction to identify and promote opportunities for continuous professional development and training needs linked to the NISCC's re-registration requirements, the Trust's appraisal and individual learning and development processes.

8.3 Support-the provision of guidance and support with regard to professional development, organisational remit and personal well being.

8.4 Engagement with the Organisation- appropriate induction into the organisation and an ongoing focus on the individual supervisee's opportunities to fully participate in and contribute to the organisation.

9.0 METHODS OF SUPERVISION

9.1 Professional supervision is a process as opposed to an event. It facilitates the identification and review of individual performance, the attainment of organisational objectives, personal and professional development and the individual worker's engagement with the organisation.

9.2 Professional supervision can involve a number of models: one-to-one supervision where one worker is given responsibility to work with another to meet certain organisational, professional and personal objectives; group supervision; team supervision; and mentoring by Senior or Principal Practitioner staff.

9.3 The central principle, irrespective of which methods are used, is that the line manager is responsible for ensuring that all four functions of supervision are formally actioned and recorded.

10.0 STANDARDS

10.1 All staff should be provided with regular and formal professional supervision. In those circumstances in which staff are line-managed by an individual who is not a registered social worker, individual professional supervision should be available to the staff member on at least a quarterly basis.

10.2 Where the supervisor is absent long-term from work (because of e.g. sick leave) alternative arrangements should be made by senior management to provide supervision.

10.3 In relation to those social work staff engaged in the Assessed Year in Employment (AYE) process, the AYE registrant must receive professional supervision at least every two weeks during the first six months and thereafter at least monthly if this is agreed at the Interim AYE Review. "Supervision must be recorded and should be undertaken in formally planned one to one sessions conducted by a registered social worker with appropriate experience. One to one supervision may be additionally supported by mentoring, group supervision and support." (Standard 3 Assessed Year in Employment (AYE) for Newly Qualified Social Workers in NI Revised Guidance for registrants and Employers NISCC 2010).

10.4 Professional supervision should be planned and facilitate an opportunity for reflection and discussion.

10.5 All professional supervision arrangements should be contextualised within a written agreement between the supervisor and supervisee which should be drawn up within the first six weeks of the commencement of the supervisory relationship. The agreement should include: respective roles and responsibilities; the frequency of supervision; and arrangements for the recording of supervision.

10.6 All professional supervision sessions should be recorded with copies signed and retained by both the supervisee and supervisor. A copy of the minutes of each professional supervision session should be retained in the supervisee's professional supervision file.

10.7 Tri-partite meetings between the supervisee, line manager and professional supervisor should be held on at least an annual basis to review the supervisee's overall progress and development, to identify areas and related goals in which the supervisee would benefit from specific training and practice opportunities and to establish an agreed plan with named responsibility for any actions for the achievement of same to be reviewed at the next tri-partite meeting.

10.8 The individual tri-partite meetings should be minuted and signed by all parties with a copy retained in the supervisee's professional supervision file.

10.9 The Associate Directors of Social Work will have responsibility for the establishment of assurance arrangements in each Service Area as part of the overarching Service Area Assurance Framework to ensure compliance with the Policy.

10.10 The Service Area will be responsible for ensuring that the requisite resources are available to ensure compliance with this Policy.

11.0 AUDIT

11.1 Senior managers are responsible for assuring the quality of supervision and the performance of staff. To this end they should regularly audit small random samples of case files and supervision records to ensure adherence to policy and the provision of high-quality supervision.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

John Growcott

_____ **Date:** _____**22/1/13**_____

Name Author
John Growcott

Cecil Worthington

_____ **Date:** _____**20/2/13**_____

Name Director
Cecil Worthington

Belfast Health and Social Care Trust
caring supporting improving together

Reference no: SG 57/09

Title:	**Adult Services Social Work Supervision policy standards and criteria**			
Author(s)	John Growcott, Co-Director Social Work & Social Care Governance			
Ownership:	Cecil Worthington, Executive Director of Social Work			
Approval by:	Associate Directors of Social Work/Social Care Steering Group Standards and Guidelines Committee Trust Policy Committee Executive Team Meeting		**Approval date:**	September 2013 22/1/2014 17/2/2014 19/2/2014
Operational Date:	March 2014		**Next Review:**	March 2017
Version No.	3	**Supercedes**	V2 - Corporate Professional Supervision Policy for Social Work Staff in Adult Services-Feb 2013-2015	
Key words	Professional supervision			
Links to other policies	This Policy should be located in the Adult Social & Primary Care Section in the Policy & Guidelines Intranet Page			

Date	Version	Author	Comments
01/10/2009	1	John Growcott	Professional Social Work Corporate Supervision Policy Standards & Guidelines Committee Approved January 2010 Review Date October 2011
01/02/2012	1.1	John Growcott	Review of policy – date change only
24/10/2012	2	John Growcott	For review in new template
19/12/2013	2.1	John Growcott	Additions include policy being reviewed and substantially rewritten – reformatted following on from an internal audit review. The recommendations identified in the review were incorporated into the revised document. Name change. Sent to Standards and Guidelines.

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

This revised Policy Supercedes the previous Corporate Professional Supervision Policy for Social Work Staff in Adult Services February 2013.

1.2 Purpose

This Policy establishes the framework and minimum standards for the delivery of supervision to social work staff employed in designated social work posts across Adult Services.

The term “social work staff” as referenced in this policy relates to those Trust staff who are registered as social workers on Part 1 of the Northern Ireland Social Care Council (NISCC) Register.

The term designated “social work posts” as referenced in this policy relates to those posts in respect of which a social work qualification and the postholder’s registration on Part 1 of the NISCC Register are mandated.

2.0 DEFINITIONS/SCOPE OF THE POLICY

2.1 This is a mandatory policy. It applies to the supervision of all social work staff in designated social work posts in Adult Services including staff in Senior Management posts (Band 8a and above).

2.2 In relation to those staff who are engaged in the completion of the Assessed Year in Employment (AYE), the Policy incorporates the standard pertaining to the frequency of supervision for such staff as referenced in the Revised Guidance for Registrants and their Employers NISCC July 2010.

2.3 The term “social work staff” as referenced in this policy relates to those Trust staff who are registered as social workers on Part 1 of the Northern Ireland Social Care Council (NISCC) Register.

2.4 The term designated “social work posts” as referenced in this policy relates to those posts in respect of which a social work qualification and the postholder’s registration on Part 1 of the NISCC Register are mandated.

3.0 ROLES/RESPONSIBILITIES

3.1 All social work staff in designated posts should be able to access supervision on a formal and regular basis.

3.2 All social work staff have a responsibility to prepare for and positively engage with the supervisory process. Supervision is a process not an event. It entails preparation, open discussion and the implementation of decisions. Both supervisors and supervisees have a responsibility to contribute positively to this process.

3.3 Senior managers should ensure that the necessary resources are in place to facilitate the full implementation of the Policy.

3.4 Senior Managers should establish arrangements to provide assurance as to the individual Service Areas' compliance with the standards specified in this policy.

3.5 Professional supervision will be based on anti-discriminatory principles and sensitive to differences between backgrounds and experiences of the supervisor and supervisee respectively.

4.0 KEY POLICY PRINCIPLES

Supervision is a process which is centred on the following functions:

4.1 The promotion of the supervisee's competent, accountable performance **(management function)**.

4.2 The continuing professional development of the supervisee **(development function)**.

4.3 The provision of personal support to the supervisee **(support function)**.

4.4 The process of engaging the supervisee with the organisation **(mediation function)**.

4.5 The supervisor and supervisee's shared consideration, reflection, and analysis of the knowledge, skills and related evidence base underpinning service delivery are important elements of the supervisory process.

4.6 Supervision affords opportunities for the supervisor and supervisee to address and develop the breadth and depth of the supervisee's competencies and to identify areas for learning and practice development.

4.7 Supervision processes - content, length, frequency, format and style-- should be reviewed by the supervisor and the supervisee on an ongoing basis.

4.8 The principal method of professional supervision within the Trust is one-to-one supervision where one worker is given the responsibility to work with another worker to meet certain organisational, professional and personal objectives.

4.9 Other supervisory models include group supervision; Team supervision; coaching; and mentoring.

5.0 IMPLEMENTATION OF POLICY

5.1 This is a mandatory policy. It applies to the supervision of all social work staff in designated social work posts in Adult Services including staff in Senior Management posts (Band 8a and above).

5.2 The Trust is required to achieve compliance with the DHSSPSNI strategic workforce target as referenced in Personal Social Services Development and Training Strategy 2006-20016 that all Social Services Team Leaders and Line Managers will have completed training in supervision and appraisal within two years of appointment to post.

Registered social work staff in Adult Services engaged in the delivery of line management and professional supervision should be afforded appropriate opportunities to participate in training and learning and development programmes to enhance their requisite knowledge and skills base in these roles.

6.0 MONITORING

6.1 Senior Managers are responsible for assuring the quality of supervision. To this end they should establish arrangements to audit randomised samples of supervision records as part of the respective Service Area audit schedule structures.

7.0 EVIDENCE BASE / REFERENCES

7.1 The formatting of this Policy broadly mirrors the Supervision Policy, Standards, and Criteria - Guidance for Northern Ireland Health and Social Care Trusts Revised 2013 (Children's Social Work Services).It reflects the emphasis in professional social work literature on the significance of professional supervision incorporating organisational and reflective dimensions to the development of the knowledge and skills base of social work staff and the delivery of qualitative services. It complies with the requirements in respect of the supervision of social work staff referenced in the Northern Ireland Social Care Council (NISCC) Code of Practice and the Scheme for the Delegation of Statutory Functions.

8.0 CONSULTATION PROCESS

8.1 Consultation process has involved a structured engagement of Trust social work staff overseen by the Associate Directors of Social Work.

9.0 APPENDICES / ATTACHMENTS

To be included as required.

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:
Major impact ☐
Minor impact ☐
No impact ☐

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

_____ **Date: _____March 2013_____**

Name John Growcott
Title Co-Director of Social Work & Social Care Governance

_____ **Date: _____March 2013_____**

Name Cecil Worthington
Title Executive Director of Social Work

Belfast Health and Social Care Trust
caring supporting improving together

INVESTORS IN PEOPLE | Silver Until 2022

Staff Development Review Guidance

Updated July 2019

CONTENTS

Background and Introduction

The vision of the Belfast Trust is to "be one of the safest, most effective and compassionate health and social care organisations". To support this the Trust endorses and continues to develop a culture of lifelong learning which enables staff to provide a service which focuses on the needs of patients and clients, meets their expectations and achieves the targets set for delivery. The Trust is committed to ensuring staff feel valued, motivated, engaged, and have the knowledge and skills required to provide safe, compassionate, person centred care to patients and clients.

The Staff Development Review (SDR) process is based on the principles of good people management, and facilitates the development of services to better meet the needs of patients and clients through investment in staff development. It supports staff in understanding what is expected of them in their role, how they contribute to the overall success of the Trust and how they can develop themselves within their own role and for future career progression. The SDR process incorporates the Knowledge and Skills Framework (KSF), Key Trust objectives and a review of Trust Values.

The Staff Development Review (SDR)

The Staff Development Review (SDR) is a structured discussion between a *Reviewee* (individual staff member) and a *Reviewer* (usually their line manager) that culminates in the development of a comprehensive Personal Development Plan (PDP). The PDP should reflect the specific development needs of an individual following exploration of their KSF post outline and individual contributions to Trust objectives. The review should also incorporate a review of the Trust Values and how these are being 'lived' by the *Reviewee*.

Knowledge and Skills Framework (KSF):

This defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver high quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The KSF lies at the heart of the career progression strand of Agenda for Change and applies to all staff except doctors and dentists.

Trust Objectives:

There are five key objectives, which inform the Trust's Strategic Direction and Priorities: Safety, Quality and Experience; Service Delivery; People and Culture; Strategy and Partnerships and Resources. Individual staff contribute to the successful delivery of these objectives via Team and Directorate Management Plans.

This integrated approach to Staff Development Review, which links the Knowledge and Skills of staff to the contribution of staff in the delivery of key Trust Objectives, will ensure staff are supported to deliver safe, compassionate patient centred care. It will also ensure the Trust can deliver a service that prioritises patient and client safety and within which continuous improvement is embedded at all levels of the organisation.

Significant work has been undertaken in partnership with Trade Union colleagues in the development of KSF post outlines to support this approach.

The benefits are as follows:-

i. Creates a clear link between supporting the development of staff to the delivery of safe, compassionate patient centred care and the achievement of the Trusts aims and objectives;

ii. Provides a structured process where these important matters can be discussed as part of **one** meeting;

iii. It will allow for a meaningful discussion that supports staff to understand what is expected of them in their role as well as reviewing their application of knowledge and skills;

iv. It will enable the development of a comprehensive Personal Development Plan (PDP) that will be beneficial to the individual

HSC Values

The HSC Values were developed through extensive engagement with patients, clients and staff. These values are important and reflect the principles by which we should work, guiding our attitudes and behaviours, the decisions we make and what we expect of one another.

As the Trust is committed to living the values, the Staff Development Review process is a key opportunity for reflection for staff and their Reviewer and to identify any areas of strength and/or further personal development. The values should be referenced early in the meeting and should form part of any reflection on the past year's achievements and progress made.

Staff Development Review (SDR) – Process

There are four key elements which need to be discussed within the Review meeting:-

1. Review of the Past Year – Joint discussion and feedback on the past year which should cover any achievements including KSF, individual objectives and

contributions, PDP and how the Trust values have been demonstrated in undertaking your day-to-day role and interactions with others.

2. KSF Development Review – discussion re the knowledge and skills required for the post, as set out in the KSF post outline

3. Individual Objectives & Contributions - Joint discussion and agreement on individual contributions to Team and Directorate Plans which support the Trust to successfully deliver on its overall objectives

4. Personal Development Plan - Discussion and agreement of a comprehensive Personal Development Plan (PDP) based on both KSF and individual contributions to Trust Objectives.

The outputs from these four elements will be recorded on the supporting paperwork (Appendix 1).

During the Staff Development Review Process the Reviewer and the Reviewee will discuss, agree and record whether or not the agreed knowledge and skills, and objectives/contributions have been achieved.

The Trust, through the KSF Accountability Group and in partnership with staff groups and Trade Union representatives, has been developing KSF post outlines for all relevant staff groups. This process is on-going with a defined action plan for completion and will ensure, once concluded, all staff will have a KSF post outline.

Training on the Staff Development Review process is available through the Trust's Human Resources Directorate for all Reviewers and Reviewees. It is mandatory that all Reviewers complete training before undertaking staff reviews.

Staff Development Review (SDR) – Who it applies to

The Staff Development Review process will apply to all staff (including Bank and Temporary staff) with the exception of Medical/Dental Staff, who have separate appraisal arrangements. All staff who are new to the Trust must have their first SDR meeting and develop a personal development plan no later than six months after taking up post.
Staff who move to a new post within the Trust, should have an SDR meeting no later than three months after taking up their new post.

HRPTS (Human Resources, Payroll, Travel and Subsistence) System

The HRPTS system is not being used to record the content of Staff Development Review meetings. There is however, a requirement that the completion of the review is noted within HRPTS to enable Directorates to maintain accurate records and allow for reporting on compliance for accountability purposes. Separate guidance is available for the recording of reviews on HRPTS.

Appendix C

Sample Appraisal Form for Band 7 Dietitian – MAH

Personal Contribution Plan (Page 1)

Name: X **Service Group: Learning Disability**
Reporting Year: November 2020 **Band: 7**

Summary Sheet

A CULTURE OF SAFETY & QUALITY We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the quality and safety of services	**OUR PEOPLE** We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce
CONTRIBUTIONS	**CONTRIBUTIONS**
Ensure mandatory training is up to date	Participate at dietetic team and staff meetings
Adherence to care pathways & policies at departmental & regional level	Participate at Joy at Work meetings
Evidence based practice & undertake dietetic training to deliver an excellent service	Joint approach with MAH staff & colleagues
HCPC Registered	Supervision and education of Dietetic Support Worker & Dietetic students
Member of Joy at Work for MAH	
CONTINUOUS IMPROVEMENT We will seek to be a leading edge Trust through innovation at all levels in the organisation	**RESOURCES** We will work to optimise the resources available to us to achieve shared goals
CONTRIBUTIONS	**CONTRIBUTIONS**
Attend team and staff meetings	Update dietary resources
Completing regular supervision.	Continue to update dietary resources as able
Develop knowledge to deliver an excellent service for learning disability & ongoing CPD	Maintain database
Dietetic Service development for Learning Disability	
PARTNERSHIPS We will work collaboratively with all stake holders and partners to improve health and wellbeing and tackle inequalities and social exclusions	**Name of individual:** Claire Gorman **Signature of individual:** _____ **Date:** 03/11/20
CONTRIBUTIONS	
Departmental and Multi-disciplinary Team Work in LD, MAH & Dietetics	
Liaise with catering service	**Name of reviewer:**_____ **Signature of reviewer:**_____ **Date:**_____
Member of Joy at Work Group for MAH	

Personal Contribution Plan (Page 2)

A CULTURE OF SAFETY & QUALITY We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the quality and safety of services		
CONTRIBUTIONS (SMART)	***How have you contributed? (Provide any other comments either person wishes to make)***	**Areas for Development (To be discussed during PDR)**
Ensure mandatory training is up to date.	See Community Mandatory training spreadsheet for current up-to-date training	Mandatory training outstanding: • CPR • Equality • HIV Awareness • Behaviour Change Continue to inform team leader when training completed
Adherence to care pathways and policies at departmental and regional level.	Continue to adhere to Adult Dietetic Regional Care Pathways, NICE Guidelines, HCPC Standards & Dept. guidelines and updates. Reading journals and CN/Dietetic Today magazine to ensure keeping up to date with evidence based practice	Continue to comply with policies and protocols Continue to read journals and adhere to evidence based practice

Evidence based practice to provide a high quality dietetic service to LD adults in MAH Undertake dietetic training to allow delivery of an excellent service	Following departmental and regional care pathways and policies. Journal subscriptions with BDA, Clinical Nutrition, PEN for up-to-date information & BDA mental health group updates. Member of NI BDA Member of the BDA Mental Health specialist group Up to date with current Learning Disability & Dietetic guidelines Maintaining CPD portfolio.	To attend Behaviour Change study day when available. To attend Introduction to Learning Disability & Mental Health BDA training BDA Advanced Dietetics in Mental Health Continue to maintain registration Continue to comply with policies and protocols Attend BDA Mental Health meetings at least annually Attend NI BDA meeetings Attend courses and conferences relevant to my current specialism
Hold current HCPC registration	Keep HCPC registration up to date	
Member of the Joy at Work MAH group	Participate in regular meetings & any projects to be involved in	To attend meetings & liaise with Team Leader & Dietetic Manager

Personal Contribution Plan (Page 3)

CONTINUOUS IMPROVEMENT We will seek to be a leading edge Trust through innovation at all levels in the organisation		
CONTRIBUTIONS (SMART)	***How have you contributed?*** **(Provide any other comments either person wishes to make)**	**Areas for Development (To be discussed during PDR)**
Maintain professional membership of BDA, HCPC & BDA Mental Health Group	BDA membership & HCPC membership. Registered with BDA Mental Health specialist group membership to ensure increase knowledge within LD & mental health	Attend BDA Mental Health meeting at least annually Continue BDA Mental Health membership Liaising with dietitians from other centres/trusts Join other groups relevant to current or future specialisms

Attend team and staff meetings	Attend Dept. meetings and participated when required. Team meetings – carried out tasks set by team lead in appropriate timeframe. MAH AHP Team meetings –attend & participate as required	
Completing regular supervision	Continue regular supervision with team lead	
Develop knowledge to deliver an excellent service to current and other clinical areas Ongoing CPD	Maintaining CPD portfolio Continue to adhere to Adult Dietetic Regional Care Pathways, NICE Guidelines, HCPC Standards & Dept. guidelines and updates. Reading journals and CN/Dietetic Today magazine to ensure keeping up to date with evidence based practice.	To attend: • BDA Introduction to LD & mental Health training • Behaviour Change Study Day when available
Ongoing Dietetic LD Service development	Aim to work towards improvement in the screening of LD patients & referral process Aim to undertake a new healthy eating initiative on site at MAH when possible Aim to improve the catering service for LD inpatients	Training/education with the staff about recording MUST/weekly weights & when to refer to Dietetics To develop a programme on site for healthy eating & weight loss for appropriate patients Attending Catering meetings & liaising with catering staff on the ward & the Catering Manager
Consider writing up development work/audits for conferences (abstracts)	N/A	Assess areas for audit and development Gather information/evidence through current guidelines, literature searches, from other centres

Personal Contribution Plan (Page 4)

PARTNERSHIPS We will work collaboratively with all stake holders and partners to improve health and wellbeing and tackle inequalities and social exclusions		
CONTRIBUTIONS (SMART)	***How have you contributed?*** **(Provide any other comments either person wishes to make)**	**Areas for Development (To be discussed during PDR)**
Departmental and Multi-disciplinary Team Work	Contribution at team and larger staff meetings Attending LD team meetings, LD ward rounds/PiPa meetings & participating in discussion with regards to service improvement as well as specific patient case discussions with LD team to ensure appropriate care management Attending catering meetings with regards to improving catering service & choice for LD inpatients	
Liaising with Catering service to improve Catering for MAH patients	Liaise with Catering staff & team lead	
Member of Joy at Work MAH Group	Participate in regular meetings	

Personal Contribution Plan (Page 5)

OUR PEOPLE We will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce.		
CONTRIBUTIONS (SMART)	***How have you contributed?*** **(Provide any other comments either person wishes to make)**	**Areas for Development (To be discussed during PDR)**

Participate at dietetic team and staff meetings	Attend Dept. meetings and participated when required. Team meetings – carried out tasks set by team lead in appropriate timeframe.	
Participate at Joy at Work MAH group meetings	Participate in regular meetings & projects	
Joint approach with MAH team colleagues	Participate in ward rounds and case conferences as required to help increase team work and help with discharge planning and maximise patient care. Participate in any other MAH Team meetings	
Supervision with Dietetic Support Worker & Dietetic students	Completing regular supervision with Dietetic Support Worker & providing support/direction as needed Completing supervision & relevant paperwork with students. Provide education & feedback to students. Seeking advice from team lead/colleagues on any issues with students, i.e. a failing student	

Personal Contribution Plan (Page 6)

RESOURCES We will work to optimise the resources available to us to achieve shared goals		
CONTRIBUTIONS (SMART)	***How have you contributed?*** **(Provide any other comments either person wishes to make)**	**Areas for Development (To be discussed during PDR)**
Update LD/dietary resources	Looking at current LD diet sheets/resources & how can improve these for MAH patients Looking at Paris notes & how to improve Dietetic write-up using Assessment templates	

Maintain database	Maintained database as needed	Continue to ensure database is maintained and updated

Belfast Health and Social Care Trust

TITLE	**Assistance to Study Policy.**

Summary	Policy for applying for and approving applications for assistance to study.
Purpose	To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance and/or leave to study.
Operational date	29th September 2009
Review date	29th September 2010
Version Number	1.2
Supersedes previous	Legacy Study Leave and Assistance to Study Policies
Director Responsible	Marie Mallon, HR Director
Lead Author	Robin Arbuthnot
Lead Author, Position	Senior Learning and Development Manager
Additional Author(s)	Bernard Madden, Senior Learning and Development Facilitator
Department / Service Group	Human Resources
Contact details	Robin Arbuthnot, Senior Learning and Development Manager, 028 9063 1360 [redacted]

Reference Number	
Supercedes	Legacy Study Leave and Assistance to Study policies

Date	Version	Author	Comments

04/07/08	0.1	R Arbuthnot	Initial Draft
18/09/08	0.2	R Arbuthnot	2nd Draft following consultation
09/01/09	0.3	R Arbuthnot	3rd Draft following consultation
24/02/09	0.4	R Arbuthnot	4th Draft following consultation
13/03/09	1.0	R Arbuthnot	Final Version
24/09/09	1.1	R Arbuthnot	Amended Travel Arrangements
21/05/10	1.2	R Arbuthnot	Amended Study Leave Form & Change of Document Name.

Policy Record

		Date	**Version**
Author (s)	Approval	13/03/09	1.0
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Summary

Reference No:

Title:

Assistance to Study Policy

Purpose:

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study or for any other learning and development activity which has a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

Objectives:

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

Policy Statement(s):

This policy is based on the following core principles:

- All staff require learning and development in their roles;
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan;
- Access to learning and development opportunities is subject to service delivery requirements;
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right;
- Learning and development must be appropriate to the role of the individual in the organisation;
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record by the Learning and Development function within HR;
- All learning and development must be evaluated through the individual's Personal Development Plan;
- All staff should be treated equitably with regards applications for assistance to study.

Chief Executive/Director	**Author**
Date:	**Date:**

ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the four values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of the Trust's Learning and Development Strategy 2008-2011.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by Beeches Management Centre, Beeches Nursing and Midwifery Education Unit or by Beeches Centre for Professional Development of Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of openness and trust, respect and dignity, learning and development and accountability. It is also the aim of this policy to support staff in both their professional and career development.

4 Principles

4.1 This policy is based on the following core principles:

4.1.1 All staff require learning and development in their roles;

4.1.2 All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan;

4.1.3 Access to learning and development opportunities is subject to service delivery requirements;

4.1.4 Funding and leave is provided at the discretion of the Trust and should not be regarded as a right;

4.1.5 Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust;

4.1.6 All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record by the Learning and Development function within HR;

4.1.7 All learning and development must be evaluated through the individual's Personal Development Plan;

4.1.8 All staff should be treated equitably with regards applications for assistance to study.

5 Definitions

5.1 For the purposes of this policy, the following definitions should be followed:

5.1.1 Learning and development activity – any ‘off-the-job’ formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

5.1.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it.

5.1.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

5.1.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

5.1.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

6 Decision Making Criteria

6.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

6.2 Part A: Applications must meet both of these requirements:

6.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

6.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

6.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

6.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

6.3.2 The relevance of the proposed learning and development activity to the individual's job;

6.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

6.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

6.3.5 Any previous learning and development support provided to the individual and whether they have attended this training previously;

6.3.6 The individual's capacity to commit to undertake the activity;

6.3.7 The numbers of staff applying for the same or similar activity;

6.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

6.3.9 The overall length and cost of the activity

6.4 A manager must inform the member of staff in writing of their decision to authorise or refuse the application. In cases where an application is refused, the manager should detail the reasons as to why it has been refused. If a member of staff is unhappy with the decision they receive they should attempt to resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

6.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

7 Continuing Professional Development (CPD)

7.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes. This policy aims to support staff undertaking a formal education or training programme related to their role and which carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

8 Funding entitlements and leave

8.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the funding/entitlements available:

Type of development	Level of funding (course fees, registrations, conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

8.2 An application which has a direct cost implication or a requirement for leave from work must be signed off by the appropriate level of management as stated on the Non Stock Trust Authorisation Framework.

8.3 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust. A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust. Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

8.4 For examinations, staff will be entitled to:

8.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

8.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

8.4.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

8.5 Managers will be required to maintain accurate records of examination leave granted.

8.6 No financial aid will be provided for staff who are required to resit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for resit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

8.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme, programmes of education and training sometimes build examination leave into the total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 7.4.

Studying outside of normal working hours

8.8 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

8.8.1 Part time staff who attend training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 8.1.

8.8.2 Full time staff who attend training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 8.1.

8.8.3 Shift workers or night staff who attend training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event.

8.9 Time in lieu should be taken within 3 months of the course provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

8.10 If training or education essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's roistered rest day, the rest day should be reallocated.

8.11 For personal development, study that is non essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

8.12 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff.

Day and block release.

8.13 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

8.14 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director.

Trainee Pharmacy Technician Programme

8.15 The Trust recruits staff on a two year fixed term contract to train as Pharmacy Technician. Part of the programme requires the trainees to complete a professional qualification at a local further education college. At the end of the programme the trainees are able to apply for posts in Belfast HSC Trust, any other HSC Trust or in private industry. Trainees will therefore be expected to meet 25% of the cost of the qualification and provide 25% of the time on release to the college.

Charitable funds and sponsorship

8.16 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the Application for Approval of Expenditure from Charitable Funds Form. An Application for Special Leave and/or Financial Assistance should also be completed with the appropriate approval.

9 Procedure for applying for assistance to study

9.1 The member of staff should complete the Trust's Assistance to Study Application Form (Annex E) and obtain approval from their line manager.

9.2 The manager considers the application as per policy and if approved, the application must be signed off by the appropriate person on the Trust's Non Stock Authorisation Framework.

9.3 The decision, whether positive or negative, must be communicated to the member of staff by the manager in writing (Annexes A and B).

9.4 If approved, the member of staff should book their own activity. Service Groups will meet the costs incurred from within their own budgets. Invoices should be sent directly by the provider to the Finance Department, 16 College Street, for payment. Only invoices varying from the amount approved on the application form will be sent to managers for signature. Please note, all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education.

9.5 If travel is required, a Central Travel Booking (Staff) form (Annex F) should be completed and attached to the Assistance to Study Application form. Staff requiring travel should follow the procedures in Annex F.

9.6 The original form with any associated travel booking form should be sent to Finance and a copy of the forms sent to Learning & Development for training records to be updated. (Annex D). Managers must retain copies of application forms for their own records. Payment for courses/conferences will not be processed without the approved application form. Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

Annex A: Template letter for accepting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY

Name: _____

Date application received by manager: _____

Dear

Thank you for your application for assistance to study. Following consideration of this I am please to inform you that your application has been approved as per the following terms in conjunction with the Assistance to Study Policy:

Name of course/conference/event:

_____
_____
_____

Date(s) of course/conference/event:

_____
_____
_____

Level of funding approved: _____

Leave granted:

_____
_____
_____

Travel/expenses granted:

_____
_____
_____

Yours sincerely

Date: _____

Annex B: Template letter for rejecting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY

Name: _____

Date application received by manager: _____

Dear

Thank you for your application for assistance to study. Following consideration of this I regret to inform you that your application has been rejected for the following reasons in line with the Assistance to Study Policy.

Name of course/conference/event:

_____
_____
_____

Date(s) of course/conference/event:

_____
_____
_____

Level of funding approved: _____

Travel/expenses applied for:

_____
_____
_____

Reasons why the application has been rejected:

_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

Annex C: Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made through the normal process for claiming expenses. Staff should clearly note on their claim what course of study, conference etc the claim relates to. This should be authorised and signed off in the normal way through the appropriate level of manager and sent to Finance to be processed.

Where accommodation is required for a member of staff to attend a course, conference etc, it should be booked through the travel agent.

If meals are included as part of the course or conference, staff should not claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Annex D: Addresses to send applications to

1. Original final approved application including authorised travel requisitions to be sent to:

   Central Travel Booking Office
   Finance
   3rd Floor
   16 College Street
   Belfast
   BT1 6BT

2. Copy of final approved application to be sent to:

   Learning & Development
   3rd Floor McKinney House
   Musgrave Park Hospital
   Stockman's Lane
   Belfast
   BT9 7JB

BELFAST HEALTH AND SOCIAL CARE TRUST

Annex E: APPLICATION FOR STUDY LEAVE AND/OR FINANCIAL ASSISTANCE FOR LEARNING & DEVELOPMENT

PLEASE COMPLETE USING BLOCK CAPITALS

NAME:		GRADE		STAFF NO:	
WORK ADDRESS			LOCATION/DEPT/SITE		
HOME ADDRESS			SERVICE GROUP		
E-MAIL ADDRESS :					
Details of Activity e.g. name of course, conference, visit etc.					
DAY/NIGHT CLASS/DISTANCE LEARNING COURSE (delete as appropriate)					
LOCATION :					
DATES (INCLUSIVE) ON WHICH LEAVE IS REQUIRED:					
PLEASE INDICATE ANY SPECIAL REQUIREMENTS:					

To be completed by Applicant (Please include amounts if known)

(please tick as appropriate)

Course/Conference Fees			£
Travelling Expenses			£
Examination Fees			£
Subsistence			£
Other			£

This application meets the requirements under the Assistance to Study Policy under one of the following:

	Tick	Percentage
Mandatory	☐	100%
Conference	☐	
Professional Development	☐	Up to 75%
Personal Development	☐	Up to 50%

Reasons for taking Course:

Signature:	**(Applicant)**	Date:	
Signature:	**(Head of Dept)**	Date:	
PRINT NAME	**(Block Capitals)**		

Reason for supporting Application:

I confirm that this application meets the requirements set out in the individual's personal development plan and/or Trust's strategic objectives.

Counter Signed:	**Dir/Co-Dir/Snr Mgr.**	Date:	
Print Name			

Budget/ Cost Centre: Funding Source:

Please ensure that travel requirements are booked using the numbered travel requisition form and processed through the approved booking agent.

Annex F: Trust procedure for booking staff travel

Courses and conferences – staff

Staff wishing to attend courses or conferences must complete an Application for Assistance to Study form in line with the Belfast Health and Social Care Trust Assistance to Study Policy (see paragraphs 9.5-9.6 of the policy).

i. Staff requiring travel in connection with this application must also complete a Central Travel Booking (Staff) form at the same time. Once completed the Central Travel Booking (Staff) form should be attached to the original copy of the application for Assistance to Study and it should be sent to finance as per paragraph vii. The booking form, as shown below, is available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:

Either

- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or

- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange booking with the travel agent on the behalf of staff.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an Application for approval of expenditure from Charitable Funds form. A copy of both the approval of expenditure form and the Learning and Development Activity form must be attached to the booking form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings without this approval.

vi. **In all cases, the form must be approved by a Level 3 or 4 manager in line with the Trust's Non Stock Authorisation Framework.** A booking/reservation cannot be made for staff, if forms are submitted with incomplete information or without the appropriate authorisation. Staff in

CTBO must return forms to the applicant if information is incomplete / lacking appropriate authorisation

vii. The fully completed and authorised booking form must be:

Posted to Central Travel Booking Office
3rd Floor
16 College St
Belfast BT 1 6BT

Or

Scanned and emailed to travelbookingoffice@belfasttrust.local

Or

Faxed to 028 90434896

viii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above).
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the form. CTBO staff will confirm arrangements with staff prior to booking.
- Send all travel details to staff named on the travel request form.

Business travel

Staff required to travel by the Trust on business must complete the form as shown at Appendix II, indicating that they are travelling on business rather than attending a course/conference. All other arrangements per paragraph 1 above apply.

Belfast Health and Social Care Trust

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____ Grade: _____ Staff No: _____

Contact Phone No: _____ Email Address: _____ Cost Centre: _____

Please state purpose of travel: Course / Conference / Business Travel/ Escorting Client/Patient
(delete as applicable)

Please ensure that details are correct when submitting this form and attach a copy of the Assistance to Study Application Form. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a new booking/amendment to a previous booking (*delete as applicable)*

If an amendment, please state previous booking ref and complete updated arrangements.

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (Dietary/Access etc):

Source of Funding
(If other than service group funding, please detail source of funding e.g. Charitable Funds).

Approved by: _____ **(Service Group Level 3/4 Manager)** _____

Please print **Signed**

_____

Date

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

Belfast Health and Social Care Trust

TITLE	**Assistance to Study Policy.**

Summary	Policy for applying for and approving applications for assistance to study.
Purpose	To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance and/or leave to study.
Operational date	May 2010
Review date	May 2013
Version Number	V2
Supersedes previous	Legacy Study Leave and Assistance to Study Policies
Director Responsible	Marie Mallon, HR Director
Lead Author	
Lead Author, Position	Senior Learning and Development Manager
Additional Author(s)	Bernard Madden, Senior Learning and Development Facilitator
Department / Service Group	Human Resources
Contact details	Robin Arbuthnot, Senior Learning and Development Manager, 028 9063 1360 [redacted]

Reference Number	TP 033/08
Supercedes	Legacy Study Leave and Assistance to Study policies

Date	Version	Author	Comments
04/07/08	0.1	R Arbuthnot	Initial Draft
18/09/08	0.2	R Arbuthnot	2nd Draft following consultation
09/01/09	0.3	R Arbuthnot	3rd Draft following consultation
24/02/09	0.4	R Arbuthnot	4th Draft following consultation
13/03/09	1.0	R Arbuthnot	Final Version
24/09/09	1.1	R Arbuthnot	Amended Travel Arrangements
21/05/10	1.2	R Arbuthnot	Amended Study Leave Form & Change of Document Name.

Policy Record

		Date	Version
Author (s)	Approval	13/03/09	1.0
Director Responsible	Approval		

Approval Process – Trust Policies

Policy Committee	Approval		
Executive Team	Authorise		
Chief Executive	Sign Off		

Approval Process – Clinical Standards and Guidelines

Standards and Guidelines Committee	Approval		
Policy Committee	Approval		
Executive Team	Authorise		
Appropriate Director	Sign Off		

Summary

Reference No:

Title:

Assistance to Study Policy

Purpose:

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study or for any other learning and development activity which has a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

Objectives:

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

Policy Statement(s):

This policy is based on the following core principles:

- All staff require learning and development in their roles;
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan;
- Access to learning and development opportunities is subject to service delivery requirements;
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right;
- Learning and development must be appropriate to the role of the individual in the organisation;
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record by the Learning and Development function within HR;
- All learning and development must be evaluated through the individual's Personal Development Plan;
- All staff should be treated equitably with regards applications for assistance to study.

William McKee

Chief Executive/Director

Author

ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the four values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of the Trust's Learning and Development Strategy 2008-2011.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by Beeches Management Centre, Beeches Nursing and Midwifery Education Unit or by Beeches Centre for Professional Development of Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of openness and trust, respect and dignity, learning and development and accountability. It is also the aim of this policy to support staff in both their professional and career development.

4 Principles

4.1 This policy is based on the following core principles:

4.1.1 All staff require learning and development in their roles;

4.1.2 All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan;

4.1.3 Access to learning and development opportunities is subject to service delivery requirements;

4.1.4 Funding and leave is provided at the discretion of the Trust and should not be regarded as a right;

4.1.5 Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust;

4.1.6 All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record by the Learning and Development function within HR;

4.1.7 All learning and development must be evaluated through the individual's Personal Development Plan;

4.1.8 All staff should be treated equitably with regards applications for assistance to study.

5 Definitions

5.1 For the purposes of this policy, the following definitions should be followed:

5.1.1 Learning and development activity – any ‘off-the-job’ formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

5.1.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it.

5.1.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

5.1.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

5.1.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

6 Decision Making Criteria

6.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

6.2 Part A: Applications must meet both of these requirements:

6.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

6.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

6.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

6.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

6.3.2 The relevance of the proposed learning and development activity to the individual's job;

6.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

6.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

6.3.5 Any previous learning and development support provided to the individual and whether they have attended this training previously;

6.3.6 The individual's capacity to commit to undertake the activity;

6.3.7 The numbers of staff applying for the same or similar activity;

6.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

6.3.9 The overall length and cost of the activity

6.4 A manager must inform the member of staff in writing of their decision to authorise or refuse the application. In cases where an application is refused, the manager should detail the reasons as to why it has been refused. If a member of staff is unhappy with the decision they receive they should attempt to resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

6.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

7 Continuing Professional Development (CPD)

7.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes. This policy aims to support staff undertaking a formal education or training programme related to their role and which carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

8 Funding entitlements and leave

8.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the funding/entitlements available:

Type of development	Level of funding (course fees, registrations, conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

8.2 An application which has a direct cost implication or a requirement for leave from work must be signed off by the appropriate level of management as stated on the Non Stock Trust Authorisation Framework.

8.3 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust. A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust. Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

8.4 For examinations, staff will be entitled to:

8.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

8.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

8.4.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

8.5 Managers will be required to maintain accurate records of examination leave granted.

8.6 No financial aid will be provided for staff who are required to resit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for resit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

8.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme, programmes of education and training sometimes build examination leave into the total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 7.4.

Studying outside of normal working hours

8.8 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

8.8.1 Part time staff who attend training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 8.1.

8.8.2 Full time staff who attend training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 8.1.

8.8.3 Shift workers or night staff who attend training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event.

8.9 Time in lieu should be taken within 3 months of the course provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

8.10 If training or education essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's roistered rest day, the rest day should be reallocated.

8.11 For personal development, study that is non essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

8.12 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff.

Day and block release.

8.13 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

8.14 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director.

Trainee Pharmacy Technician Programme

8.15 The Trust recruits staff on a two year fixed term contract to train as Pharmacy Technician. Part of the programme requires the trainees to complete a professional qualification at a local further education college. At the end of the programme the trainees are able to apply for posts in Belfast HSC Trust, any other HSC Trust or in private industry. Trainees will therefore be expected to meet 25% of the cost of the qualification and provide 25% of the time on release to the college.

Charitable funds and sponsorship

8.16 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the Application for Approval of Expenditure from Charitable Funds Form. An Application for Special Leave and/or Financial Assistance should also be completed with the appropriate approval.

9 Procedure for applying for assistance to study

9.1 The member of staff should complete the Trust's Assistance to Study Application Form (Annex E) and obtain approval from their line manager.

9.2 The manager considers the application as per policy and if approved, the application must be signed off by the appropriate person on the Trust's Non Stock Authorisation Framework.

9.3 The decision, whether positive or negative, must be communicated to the member of staff by the manager in writing (Annexes A and B).

9.4 If approved, the member of staff should book their own activity. Service Groups will meet the costs incurred from within their own budgets. Invoices should be sent directly by the provider to the Finance Department, 16 College Street, for payment. Only invoices varying from the amount approved on the application form will be sent to managers for signature. Please note, all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education.

9.5 If travel is required, a Central Travel Booking (Staff) form (Annex F) should be completed and attached to the Assistance to Study Application form. Staff requiring travel should follow the procedures in Annex F.

9.6 The original form with any associated travel booking form should be sent to Finance and a copy of the forms sent to Learning & Development for training records to be updated. (Annex D). Managers must retain copies of application forms for their own records. Payment for courses/conferences will not be processed without the approved application form. Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

Annex A: Template letter for accepting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY

Name: _____

Date application received by manager: _____

Dear

Thank you for your application for assistance to study. Following consideration of this I am please to inform you that your application has been approved as per the following terms in conjunction with the Assistance to Study Policy:

Name of course/conference/event:

_____
_____
_____

Date(s) of course/conference/event:

_____
_____
_____

Level of funding approved: _____

Leave granted:

_____
_____
_____

Travel/expenses granted:

_____
_____
_____

Yours sincerely

Date: _____

Annex B: Template letter for rejecting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY

Name: _____

Date application received by manager: _____

Dear

Thank you for your application for assistance to study. Following consideration of this I regret to inform you that your application has been rejected for the following reasons in line with the Assistance to Study Policy.

Name of course/conference/event:

_____
_____
_____

Date(s) of course/conference/event:

_____
_____
_____

Level of funding approved: _____

Travel/expenses applied for:

_____
_____
_____

Reasons why the application has been rejected:

_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

Annex C: Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made through the normal process for claiming expenses. Staff should clearly note on their claim what course of study, conference etc the claim relates to. This should be authorised and signed off in the normal way through the appropriate level of manager and sent to Finance to be processed.

Where accommodation is required for a member of staff to attend a course, conference etc, it should be booked through the travel agent.

If meals are included as part of the course or conference, staff should not claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Annex D: Addresses to send applications to

1. Original final approved application including authorised travel requisitions to be sent to:

   Central Travel Booking Office
   Finance
   3rd Floor
   16 College Street
   Belfast
   BT1 6BT

2. Copy of final approved application to be sent to:

   Learning & Development
   3rd Floor McKinney House
   Musgrave Park Hospital
   Stockman's Lane
   Belfast
   BT9 7JB

BELFAST HEALTH AND SOCIAL CARE TRUST

Annex E: APPLICATION FOR STUDY LEAVE AND/OR FINANCIAL ASSISTANCE FOR LEARNING & DEVELOPMENT

PLEASE COMPLETE USING BLOCK CAPITALS

NAME:		GRADE		STAFF NO:	
WORK ADDRESS			LOCATION/DEPT/SITE		
HOME ADDRESS			SERVICE GROUP		
E-MAIL ADDRESS :					
Details of Activity e.g. name of course, conference, visit etc.					
DAY/NIGHT CLASS/DISTANCE LEARNING COURSE (delete as appropriate)					
LOCATION :					
DATES (INCLUSIVE) ON WHICH LEAVE IS REQUIRED:					
PLEASE INDICATE ANY SPECIAL REQUIREMENTS:					

To be completed by Applicant (Please include amounts if known)

(please tick as appropriate)

Course/Conference Fees			£
Travelling Expenses			£
Examination Fees			£
Subsistence			£
Other			£

This application meets the requirements under the Assistance to Study Policy under one of the following:

	Tick	Percentage
Mandatory	☐	100%
Conference	☐	
Professional Development	☐	Up to 75%
Personal Development	☐	Up to 50%

Reasons for taking Course:

Signature:	**(Applicant)**	Date:	
Signature:	**(Head of Dept)**	Date:	
PRINT NAME	**(Block Capitals)**		

Reason for supporting Application:

I confirm that this application meets the requirements set out in the individual's personal development plan and/or Trust's strategic objectives.

Counter Signed:	**Dir/Co-Dir/Snr Mgr.**	Date:	
Print Name			

Budget/ Cost Centre: Funding Source:

Please ensure that travel requirements are booked using the numbered travel requisition form and processed through the approved booking agent.

Annex F: Trust procedure for booking staff travel

Courses and conferences – staff

Staff wishing to attend courses or conferences must complete an Application for Assistance to Study form in line with the Belfast Health and Social Care Trust Assistance to Study Policy (see paragraphs 9.5-9.6 of the policy).

i. Staff requiring travel in connection with this application must also complete a Central Travel Booking (Staff) form at the same time. Once completed the Central Travel Booking (Staff) form should be attached to the original copy of the application for Assistance to Study and it should be sent to finance as per paragraph vii. The booking form, as shown below, is available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:

Either

- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or

- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange booking with the travel agent on the behalf of staff.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an Application for approval of expenditure from Charitable Funds form. A copy of both the approval of expenditure form and the Learning and Development Activity form must be attached to the booking form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings without this approval.

vi. **In all cases, the form must be approved by a Level 3 or 4 manager in line with the Trust's Non Stock Authorisation Framework.** A booking/reservation cannot be made for staff, if forms are submitted with incomplete information or without the appropriate authorisation. Staff in

CTBO must return forms to the applicant if information is incomplete / lacking appropriate authorisation

vii. The fully completed and authorised booking form must be:

Posted to Central Travel Booking Office
3rd Floor
16 College St
Belfast BT 1 6BT

Or

Scanned and emailed to travelbookingoffice@belfasttrust.local

Or

Faxed to 028 90434896

viii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above).
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the form. CTBO staff will confirm arrangements with staff prior to booking.
- Send all travel details to staff named on the travel request form.

Business travel

Staff required to travel by the Trust on business must complete the form as shown at Appendix II, indicating that they are travelling on business rather than attending a course/conference. All other arrangements per paragraph 1 above apply.

Belfast Health and Social Care Trust

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____ Grade: _____ Staff No: _____

Contact Phone No: _____ Email Address: _____ Cost Centre: _____

Please state purpose of travel: Course / Conference / Business Travel/ Escorting Client/Patient
(delete as applicable)

Please ensure that details are correct when submitting this form and attach a copy of the Assistance to Study Application Form. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a new booking/amendment to a previous booking (*delete as applicable)*

If an amendment, please state previous booking ref and complete updated arrangements.

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (Dietary/Access etc):

Source of Funding
(If other than service group funding, please detail source of funding e.g. Charitable Funds).

Approved by: _____ **(Service Group Level 3/4 Manager)** _____

Please print **Signed**

_____

Date

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

Belfast Health and Social Care Trust

Reference No: TP033/08

Title:	**Assistance to Study Policy**		
Author(s)	Catherine Shannon Senior Learning and Development Manager Marina McCarney Learning and Development Manager		
Ownership:	Marie Mallon, Deputy Chief Executive / Director of Human Resources		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	07/04/2014 10/04/2014
Operational Date:	April 2014	**Next Review:**	March 2017
Version No.	V3.1	**Supercedes**	V3 – April 2014-2017
Key words:	Study, placement, approval, development		
Links to other policies			

Date	Version	Author	Comments
20/03/2013	2.1	M McCarney	Initial draft considering impact of HRPTS
15/07/2013	2.2	M McCarney C Shannon J McAleer	Revised draft incorporating HRPTS screen input processes
15/08/2013	2.3	M McCarney S Dickey	Revised draft after input from Finance regards updates to 'Travel process'
26/09/2013	2.4	M McCarney C Shannon	Revised draft after consultation
24/03/2014	2.4	C Shannon	Trust Policy Committee approval
11/04/2014	3.0	C Shannon M McCarney	Final Version issued
28/10/2014	3.1	M McCarney	Updated document regards Finance and Travel paperwork - relating to shared service changes and requirements

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Maximising Learning and Development has been identified as one of the core values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

1.2 Purpose

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study, or for any other learning and development activity where there is a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

1.3 Objectives

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

2.0 SCOPE OF THE POLICY

This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3.0 ROLES/RESPONSIBILITIES

The specific responsibilities of Staff, Managers, Human Resources and Finance staff are outlined in the Policy.

4.0 KEY POLICY PRINCIPLES

4.1 This policy is based on the following core principles:

- All staff require learning and development in their roles
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan
- Access to learning and development opportunities is subject to service delivery requirements
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right
- Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record
- All learning and development must be evaluated through the individual's Personal Development Plan and in line with the Trust's Evaluation Framework
- All staff should be treated equitably with regards applications for assistance to study
- Priority will be given to the completion of statutory and mandatory training

4.2 Definitions

For the purposes of this policy, the following definitions should be followed:

4.2.1 Learning and development activity – any 'off-the-job' formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

4.2.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it. Further information is available in the BHSCT Statutory and Mandatory Training Policy.

4.2.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

4.2.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

4.2.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

5.2 Resources

Applications for Assistance to Study are made via the new Training Request Form which can be accessed via HRPTS in the “Appraisals, Learning and Development” area of the ESS portal.

5.3 Exceptions

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

6.0 MONITORING

HR will monitor this Policy and its use.

7.0 EVIDENCE BASE / REFERENCES

The Policies comply with legislative requirements and good practice.

8.0 CONSULTATION PROCESS

Internal stake-holders such as Staff, Trade Unions and Professional Organisations were consulted in the development of this Policy. The Policy was tabled at the Policy Sub-Committee involving Management Side and Trade Unions Side representatives and approved.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 : Flow Chart Showing Summary of Procedure Applying for Assistance to Study
Appendix 2 : Guidance on the Completion of New Training Request Form
Appendix 3 : New Training Request Form - Manager Approval Guidance
Appendix 4 : Template for rejecting an application for assistance to study
Appendix 5 : Subsistence Rates
Appendix 6 : BHSCT Procedure for Booking Staff Travel

10.0 EQUALITY STATEMENT

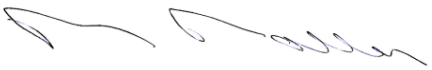
In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact ✓

SIGNATORIES
(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

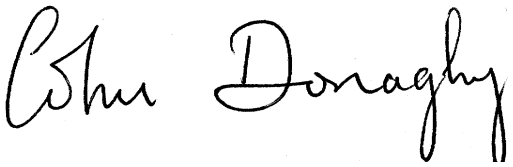
24 March 2014

_____ **Date:** _____
HR Learning & Development Manager / Author



10 April 2014

_____ **Date:** _____
Deputy Chief Executive / Director of Human Resources



10 April 2014

_____ **Date:** _____
Chief Executive

Belfast Health and Social Care Trust

ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the four values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best use of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of; treating everyone with respect and dignity, displaying openness and trust, being leading edge, maximising learning and development and being accountable. It is also the aim of this policy to support staff in both their professional and career development.

4 Decision Making Criteria

4.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

4.2 Part A: Applications must meet both of these requirements:

4.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

4.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

4.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

4.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

4.3.2 The relevance of the proposed learning and development activity to the individual's job;

4.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

4.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

4.3.5 Any previous learning and development support provided to the individual and whether they have attended this activity previously;

4.3.6 The individual's capacity to commit to undertake the activity;

4.3.7 The numbers of staff applying for the same or similar activity;

4.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

4.3.9 The overall length and cost of the activity

4.4 The member of staff will be informed via the Human Resources Payroll Travel Subsistence (HRPTS) system of the manager's decision to authorise or refuse their application. In cases where an application is refused, the manager should also detail the reasons as to why it has been refused (the template at Appendix 4 can be used for this purpose). The automated system responses should not remove the opportunity for face to face discussion between the manager and applicant (staff member) about the development activity and associated study leave requests. If a member of staff is unhappy with the decision they receive they should attempt to resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

4.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

5 Continuing Professional Development (CPD)

5.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes.

5.2 This policy aims to support staff undertaking learning and development where a formal education or training programme related to their role carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

6 Funding entitlements and leave

6.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the maximum funding/entitlements available:

Type of development	Level of funding (registrations, course / exam / conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

6.2 An application which has a direct cost implication or a requirement for leave from work must be authorised via the New Training Request Form on the HRPTS system by the appropriate level of management (See Appendices 2 & 3).

6.3 Reimbursement;

6.3.1 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust.

6.3.2 A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust.

6.3.3 Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

6.4 For examinations, staff will be entitled to:

6.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

6.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

8.5.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

6.5 Applications for examination leave must be made using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Exam Leave” must be selected from the system drop down menu. Please also provide details of the exam leave in the text box labelled, “New Note”. The system will maintain records of leave granted and records can be accessed by managers and staff.

6.6 No financial aid will be provided for staff required to re-sit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for re-sit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

6.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme, programmes of education and training sometimes build examination leave into the total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 6.5.

Requirements for Applying for Study Leave in HRPTS

6.8 Once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Study Leave” must be selected from the system drop down menu. Please also provide details of the reason for the leave in the text box labelled, “New Note”.

This application process applies to all learning and education activities that require leave from work.

Time off in lieu which has been accrued as a result of attending learning and development activity outside of scheduled working hours, should be applied for in the same manner as study leave using the “Study Leave” drop down option. Please provide details of the leave and how it was accrued in the text box labelled, “New Note”.

As per table 8.1, requests for personal development carry an entitlement of up to 50% time off to attend study. In such cases, two leave requests must be made via HRPTS e.g. one for 50% of the time as study leave and the remaining 50% as another form of leave request which will be agreed between the individual and the manager, for example, holiday leave or unpaid leave.

As a result of the approved study leave application, a study leave record will be generated in HRPTS within individual’s overall leave record.

Studying outside of normal working hours

6.9 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

6.9.1 Part time staff attending training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 6.1

6.9.2 Full time staff attending training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 6.1

6.9.3 Shift workers or night staff attending training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event as per the table in 6.1

6.10 Time in lieu should be taken within 3 months of the learning and development activity, provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

6.11 If learning and development essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's rostered rest day, the rest day should be reallocated.

6.12 For personal development, study that is non-essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

6.13 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff. Where research time is granted, this must be requested through the HRPTS system as a study leave request (see paragraph 6.8)

Day and block release.

6.14 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

6.15 Day and block release must be requested as a study leave request through the HRPTS system (see paragraph 6.8).

6.16 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director prior to the manager approving the leave request on the system.

Charitable funds and sponsorship

6.17 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the 'Application for Approval of Expenditure from Charitable Funds' form (Appendix 8). Staff will be required to sign a disclaimer section on the form to demonstrate and confirm management approval has been authorised on HRPTS.

NB: The principles of this policy apply regardless of funding source.

6.18 On approval of the 'Application for Expenditure from Charitable Funds' form, the New Training Request Form screen in HRPTS must be completed by the applicant referencing the details of the of the approval for expenditure from charitable funds. These details, including the approval date and reference numbers, should be entered in the "Description text box" of the New Training Request Form.

7 Procedure for applying for assistance to study on HRPTS

7.1 The member of staff (applicant) should complete the online 'New Training Request Form' in HRPTS. This form must always be completed *prior* to the learning or development activity being undertaken. Only in exceptional circumstances should this form be completed retrospectively, for example if the activity is required at short notice. The New Training Request Form can be located in the "Appraisals, Learning & Development" area of the Employee Self Service (ESS) screen. When all sections (fields) are fully completed, the applicant must click on the '*submit'* button to ensure the system processes the application to their line manager for consideration (see Appendix 2 for screen completion guidance).

7.2 The manager receives the online Training Request application on the HRPTS system and considers as per policy. The manager approves or rejects the application request by clicking on the appropriate button/icon on screen (see Appendices 2 & 3 for guidance).

7.3 The managers' decision to approve or reject the application will be communicated to the member of staff via a HRPTS system notification. Where an application is being rejected, this must be followed up by the manager in writing (see section 4.4 of this policy and Appendix 4 for further guidance). Where the manager does not agree with some of the details provided by the staff member on the New Training Request Form they should reject it and inform the employee to submit another New Training Request Form with the amended details.

7.4 On approval of the New Training Request Form, the member of staff should;

- book their own study/learning activity with the learning provider
- quote the appropriate Trust cost centre to the learning and development provider
- ask the learning and development provider to send the invoice to the BHSCT Finance department for payment
- ensure the learning and development provider is aware they must quote the cost centre code on the invoice

Directorates will meet the costs incurred from within their own budgets. The invoice will be forwarded to the appropriate manager for approval via the Finance Procurement and Logistics (FPL) system. Where a percentage of the total fees are rechargeable to the member of staff, the approving manager will be required to complete the recharging process using the FPM Invoice Request Form through the Trust FPL system (further guidance can be obtained from BHSCT Finance department). Please note;

- all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education
- all invoices relating to commissioned activity for AHP's need to be directed to the AHP Lead

7.5 If accommodation and/ or travel is required (beyond mileage claims), a Central Travel Booking (Staff) form (Appendix 7) should be completed and staff requiring travel should follow the procedures as indicated at Appendix 6. Staff will be required to sign a disclaimer section on the form to demonstrate and confirm management approval has been authorised on HRPTS.

7.6 Where travel (beyond mileage claims) is involved e.g. flights, train journeys, overnight accommodation; payment for courses/conferences will not be processed without the approved Central Travel Booking (CTB) application form. Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

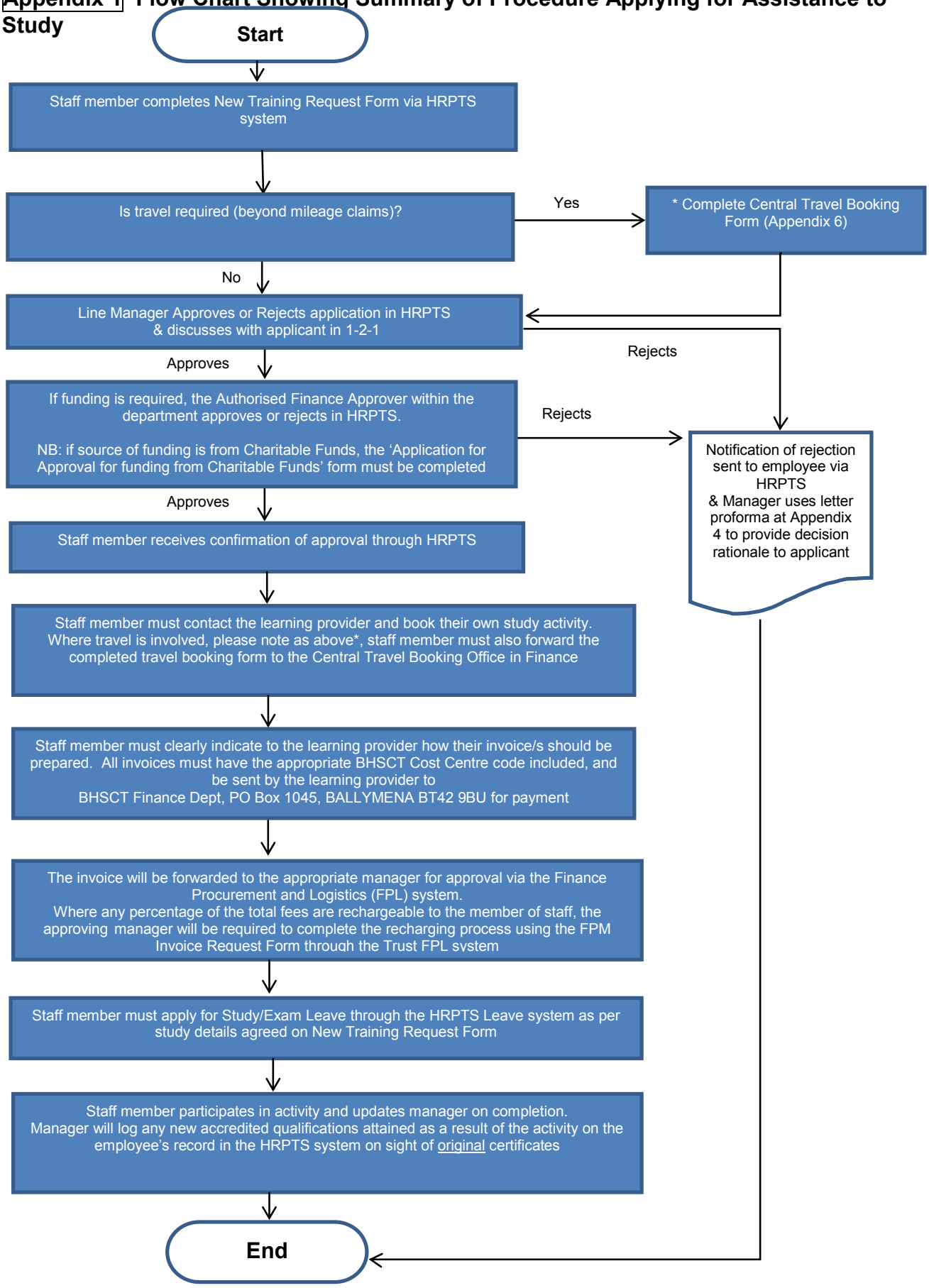
7.7 Managers must retain copies of CTB application forms for their own records.

7.8 As detailed in section 6.8, once the New Training Request Form has been approved by the manager, the individual must then also formally apply for the actual study leave days required using the Leave Request function (located in the 'Life and Work Events' area of the Employee Self Service screen) in the HRPTS system.

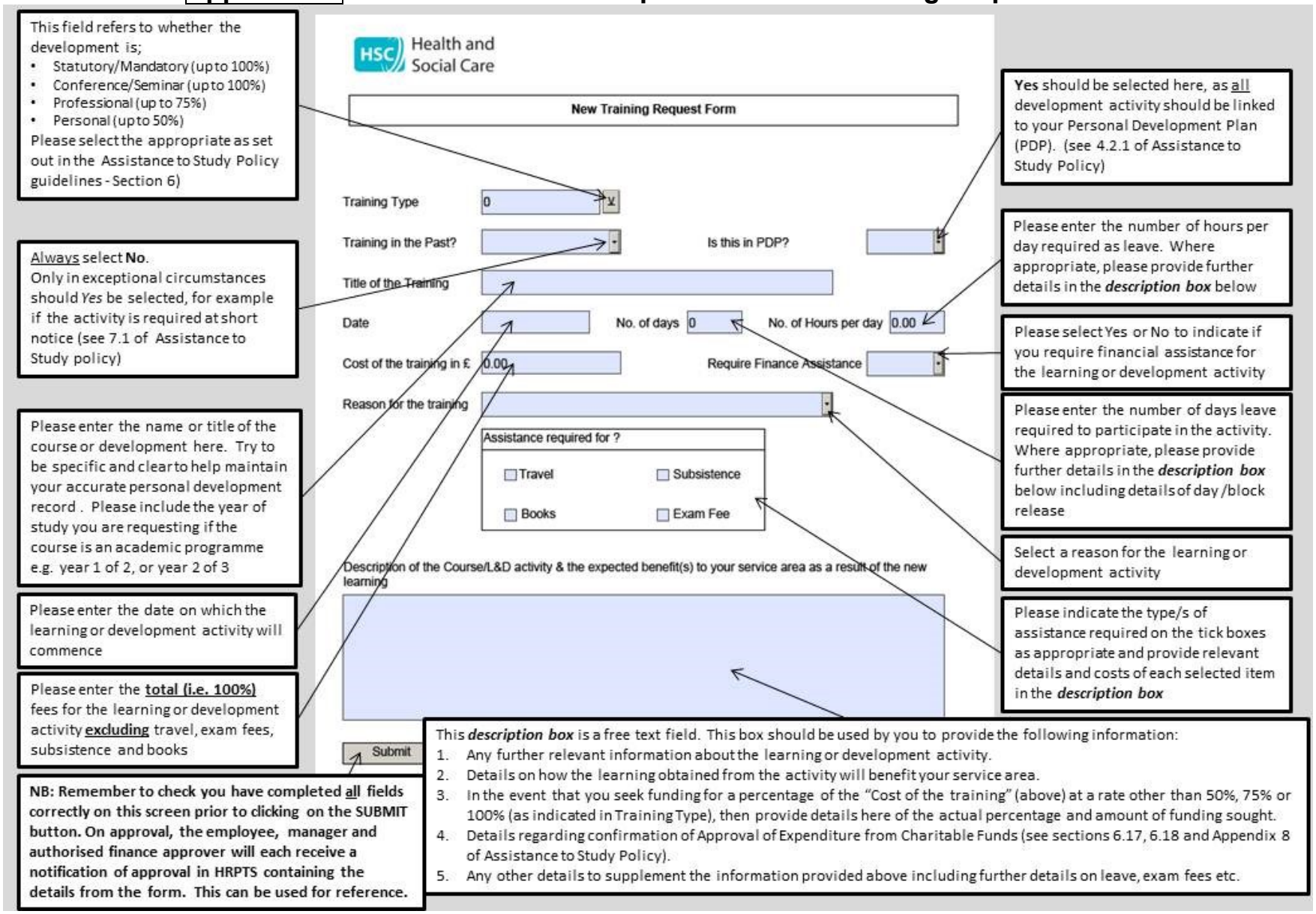
7.9 Managers should update employee's development record on HRPTS on completion of any accredited qualifications acquired through the Assistance to Study Policy. The staff record should only be updated by the manager on sight of the **original** certificates.

7.10 Please refer to Appendix 1 for a flowchart summary of the procedure for applying for assistance to study.

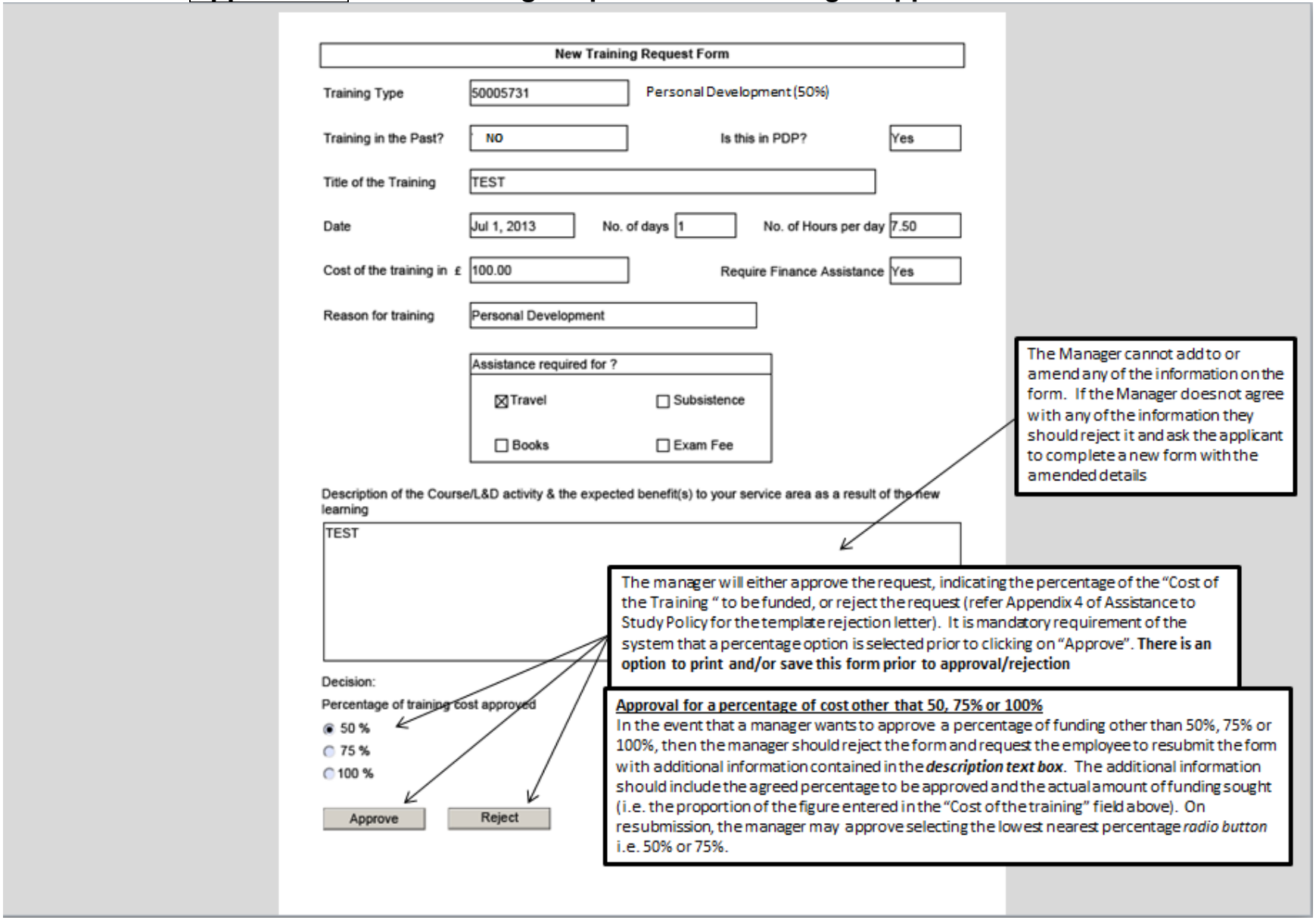
Appendix 1 Flow Chart Showing Summary of Procedure Applying for Assistance to Study



Appendix 2: Guidance on the Completion of New Training Request Form



Appendix 3: New Training Request Form - Manager Approval Guidance



Appendix 4

Template for rejecting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY RESPONSE

Name: _____

Date application received by manager: _____

Dear _____

Thank you for your application for assistance to study, details of which are below;

Name of course/conference/event:
_____
_____

Date(s) of course/conference/event:
_____

Level of funding requested: _____

Travel/expenses applied for: _____
_____

Following consideration of this application, I regret to inform you that your request has been rejected for the following reasons in line with the Assistance to Study Policy;
_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

Appendix 5

Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made via the HRPTS system in the Travel & Expenses area of the Employee Self Service (ESS) screen. Staff should clearly note on their claim what learning and development activity the claim relates to e.g. course of study, conference. This will be considered and authorised online through the appropriate manager.

Where travel (other than business mileage) and/or accommodation is required for the member of staff to attend the learning and development activity, this should be booked as per the Trust CTBO procedure (Appendix 6).

If meals are included as part of the learning and development activity (course or conference), staff should not include these in any claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Any approved application requiring authorised travel requisitions must be processed to Trust Finance Department.

Appendix 6

BHSCT Procedure for Booking Staff Travel

Courses and Conferences – staff

Staff wishing to apply to attend courses or conferences must complete the online 'New Training Request Form' screen for assistance to study requests in line with the Belfast Health and Social Care Trust Assistance to Study Policy.

i. Staff requiring travel (other than business mileage claims) in connection with their approved application must complete a Central Travel Booking (Staff) form when study approval has been received. Once completed the Central Travel Booking (Staff) form should be sent to Finance department as per paragraph vii below. The booking form (see Appendix 7), is also available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:
Either
- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) in Finance – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or
- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange a booking with the travel agent on their behalf.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an 'Application for Approval of Expenditure from Charitable Funds' form (appendix 8). A copy of the Charitable Funds form must be attached to the CTB form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings or funding without these approvals.

vi. **In all cases, forms must be approved by a level 3 or level 4 Manager in line with the Trust's Non Stock Authorisation Framework.**
A booking/reservation cannot be made for staff if forms are submitted with incomplete information or without the appropriate authorisation signatures. Staff in CTBO will return forms to the applicant if information is incomplete / lacking appropriate authorisation.

vii. The fully completed and authorised booking form/s must be;

Scanned / emailed to:
travelbookingoffice@belfasttrust.hscni.net

viii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above)
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the CTB form. CTBO staff will confirm arrangements with staff prior to booking
- Send all travel details to staff named on the travel request form

Business travel

Where staff members are required to travel by the Trust on business rather than attending a course/conference, please consult the Finance area of the BHSCT Intranet HUB for further information and guidance

http://intranet.belfasttrust.local/directorates/finance/Pages/News/Changes-to-Travel-for-BSTP-Implementation.aspx

Appendix 7

Belfast Health and Social Care Trust

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____ Grade: _____ Staff No: _____

Contact Phone No: _____ Email Address:_____ Cost Centre: _____

Please state purpose of travel: Course / Conference / Business Travel/ Escorting Client/Patient
(delete as applicable)

Please ensure that details are correct when submitting this form and it aligned to the details completed on your on-line New Training Request Form screen on HRPTS. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a 'new booking' / 'amendment to a previous booking' (*delete as applicable)*

If an amendment, please state previous booking reference and complete updated arrangements

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (e.g. Dietary, Access, etc):

Source of Funding
If other than service group funding, please detail source of funding e.g. Third Party Sponsor, Charitable Funds. (NB: Where appropriate, a separate Charitable Funds application form must be completed and approved).

EMPLOYEE DECLARATION

By signing this form I confirm that:

My application to attend this course/conference has been approved by the appropriate manager through the HRPTS system in line with the Trust Assistance to Study policy

I am responsible for ensuring that the correct level of approval has been obtained before submitting this Central Travel Booking Office form

Signature: _____ Date: _____

Approved by: _____ **Please print**

(Service Group Level 3/4 Manager) _____ **Signed**

_____ **Date**

This fully completed and authorised booking form must be;

Scanned / emailed to: travelbookingoffice@belfasttrust.hscni.net

---

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

Appendix 8

NO: 00000001

Belfast Health and Social Care Trust

Application for Approval of Expenditure from Charitable Funds

Fund name: _____ **Fund ref:** _____

All expenditure should be procured in line with Trust Policy. Include all costs eg. installation.
Explain how this use meets the charitable purpose

Expenditure details

Supporting documentation attached		*Please tick*
Goods & Services	Non-Stock Requisition/ Quotation Expenditure >£5,000 Business case proforma/ Management approval	
Research funding	Research project ref. & Certificate of Indemnity	
Salary recharge	Letters of authorisation	
Expenses incurred	Original receipts	
Building & Maintenance	Works order	
Maintenance costs	Supporting documentation, inc. value, frequency & term	

Full details of proposed expenditure

Cheque should be made payable to:

If proposed expenditure does not exceed £100, and it is of no financial benefit to the Trust that an official order be raised, please attach original invoice to this document.

Amount applied for excl. VAT: £ _____ Total: £ _____

Are you aware of any future costs which may be incurred as a result of this expenditure? ☐ Yes ☐ No

If so, state source of funding for these future costs: Fund ref.: _____ Cost centre: _____

	Signature	Block caps	Band / Grade	Date
Applicant:				

In supporting this request, I confirm that the nature of this expenditure meets the objectives of the fund and conforms with the Trust's expenditure criteria for Charitable Funds as stated in the Handbook.

	Signature	Block caps	Band / Grade	Date
Advisor signatory:				

Employee Declaration

Where applicable, by signing this form I confirm that:

My claim for expenditure from Charitable Funds has been approved by the appropriate manager through the HRPTS system in line with the assistance to study policy.

I am responsible for ensuring that the correct level of approval has been obtained before submitting the Charitable Funds form.

Signature: _____ Date: _____

For finance use only	Signature	Block caps	Band / Grade	Date
Authorised by:				

Please note that failure to **fully** complete this application may result in delays

Registered Charity No. XT1874

Blank copies of this form can be obtained by contacting; charitabletrustfunds@belfasttrust.hscni.net

Belfast Health and Social Care Trust

Reference No: TP033/08

Title:	Assistance to Study Policy		
Author(s)	Catherine Shannon Senior Learning and Development Manager Marina McCarney Learning and Development Manager		
Ownership:	Marie Mallon Deputy Chief Executive / Director of Human Resources		
Approval by:	Trust Policy Committee Executive Team	**Approval date:**	07/04/2014 10/04/2014
Operational Date:	Apr 2014	**Next Review:**	Mar 2017
Version No.	V3.0 **Supercedes**	V2 May 2010-2013	
Key words:	Study, placement, approval, development		
Links to other policies			

Date	**Version**	**Author**	**Comments**
20/03/2013	2.1	M McCarney	Initial draft considering impact of HRPTS
15/07/2013	2.2	M McCarney C Shannon J McAleer	Revised draft incorporating HRPTS screen input processes
15/08/2013	2.3	M McCarney S Dickey	Revised draft after input from Finance regards updates to 'Travel process'
26/09/2013	2.4	M McCarney C Shannon	Revised draft after consultation
24/03/2014	2.4	C Shannon	Trust Policy Committee approval
11/04/2014	3.0	C Shannon M McCarney	Final Version issued

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the four values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

1.2 Purpose

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study, or for any other learning and development activity where there is a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

1.3 Objectives

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

2.0 SCOPE OF THE POLICY

This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3.0 ROLES/RESPONSIBILITIES

The specific responsibilities of Staff, Managers, Human Resources and Finance staff are outlined in the Policy.

4.0 KEY POLICY PRINCIPLES

This policy is based on the following core principles:

- All staff require learning and development in their roles
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan
- Access to learning and development opportunities is subject to service delivery requirements
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right
- Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record
- All learning and development must be evaluated through the individual's Personal Development Plan and in line with the Trust's Evaluation Framework
- All staff should be treated equitably with regards applications for assistance to study
- Priority will be given to the completion of statutory and mandatory training

Definitions

5.1 For the purposes of this policy, the following definitions should be followed:

5.1.1 Learning and development activity – any 'off-the-job' formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

5.1.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it. Further information is available in the BHSCT Statutory and Mandatory Training Policy.

5.1.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

5.1.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

5.1.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

Key Policy Statement(s)

4.1 This policy is based on the following core principles:

4.1.1 All staff require learning and development in their roles

4.1.2 All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan

4.1.3 Access to learning and development opportunities is subject to service delivery requirements

4.1.4 Funding and leave is provided at the discretion of the Trust and should not be regarded as a right

4.1.5 Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust

4.1.6 All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record

4.1.7 All learning and development must be evaluated through the individual's Personal Development Plan and in line with the Trust's Evaluation Framework

4.1.8 All staff should be treated equitably with regards applications for assistance to study

4.1.9 Priority will be given to the completion of statutory and mandatory training

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

5.2 Resources

Applications for Assistance to Study are made via the new Training Request Form which can be accessed via HRPTS in the "Appraisals, Learning and Development" area of the ESS portal.

5.3 Exceptions

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

6.0 MONITORING

HR will monitor this Policy and its use.

7.0 EVIDENCE BASE / REFERENCES

The Policies comply with legislative requirements and good practice.

8.0 CONSULTATION PROCESS

Internal stake-holders such as Staff, Trade Unions and Professional Organisations were consulted in the development of this Policy. The Policy was tabled at the Policy Sub-Committee involving Management Side and Trade Unions Side representatives and approved.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 : Flow Chart Showing Summary of Procedure Applying for Assistance to Study
Appendix 2 : Guidance on the Completion of New Training Request Form
Appendix 3 : New Training Request Form - Manager Approval Guidance
Appendix 4 : Template for rejecting an application for assistance to study
Appendix 5 : Subsistence Rates
Appendix 6 : BHSCT Procedure for Booking Staff Travel

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. ☐

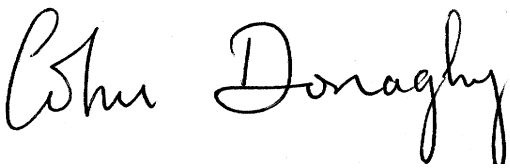
SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

10 April 2014

_____ **Date:** _____

Deputy Chief Executive/Director of Human Resources



10 April 2014

_____ **Date:** _____

Chief Executive

Belfast Health and Social Care Trust

ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the four values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best use of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of; treating everyone with respect and dignity, displaying openness and trust, being leading edge, maximising learning and development and being accountable. It is also the aim of this policy to support staff in both their professional and career development.

4 Decision Making Criteria

4.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

4.2 Part A: Applications must meet both of these requirements:

4.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

4.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

4.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

4.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

4.3.2 The relevance of the proposed learning and development activity to the individual's job;

4.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

4.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

4.3.5 Any previous learning and development support provided to the individual and whether they have attended this activity previously;

4.3.6 The individual's capacity to commit to undertake the activity;

4.3.7 The numbers of staff applying for the same or similar activity;

4.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

4.3.9 The overall length and cost of the activity

4.4 The member of staff will be informed via the Human Resources Payroll Travel Subsistence (HRPTS) system of the manager's decision to authorise or refuse their application. In cases where an application is refused, the manager should also detail the reasons as to why it has been refused (the template at Appendix 4 can be used for this purpose). The automated system responses should not remove the opportunity for face to face discussion between the manager and applicant (staff member) about the development activity and associated study leave requests. If a member of staff is unhappy with the decision they receive they should attempt to

resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

4.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

5 Continuing Professional Development (CPD)

5.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes.

5.2 This policy aims to support staff undertaking learning and development where a formal education or training programme related to their role carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

6 Funding entitlements and leave

6.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the maximum funding/entitlements available:

Type of development	Level of funding (registrations, course / exam / conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

6.2 An application which has a direct cost implication or a requirement for leave from work must be authorised via the New Training Request Form on the HRPTS system by the appropriate level of management (See Appendices 2 & 3).

6.3 Reimbursement;

6.3.1 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust.

6.3.2 A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust.

6.3.3 Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

6.4 For examinations, staff will be entitled to:

6.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

6.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

8.5.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

6.5 Applications for examination leave must be made using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Exam Leave” must be selected from the system drop down menu. Please also provide details of the exam leave in the text box labelled, “New Note”. The system will maintain records of leave granted and records can be accessed by managers and staff.

6.6 No financial aid will be provided for staff required to re-sit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for re-sit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

6.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme,

programmes of education and training sometimes build examination leave into the total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 6.5.

Requirements for Applying for Study Leave in HRPTS

6.8 Once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named "Study Leave" must be selected from the system drop down menu. Please also provide details of the reason for the leave in the text box labelled, "New Note".

This application process applies to all learning and education activities that require leave from work.

Time off in lieu which has been accrued as a result of attending learning and development activity outside of scheduled working hours, should be applied for in the same manner as study leave using the "Study Leave" drop down option. Please provide details of the leave and how it was accrued in the text box labelled, "New Note".

As per table 8.1, requests for personal development carry an entitlement of up to 50% time off to attend study. In such cases, two leave requests must be made via HRPTS e.g. one for 50% of the time as study leave and the remaining 50% as another form of leave request which will be agreed between the individual and the manager, for example, holiday leave or unpaid leave.

As a result of the approved study leave application, a study leave record will be generated in HRPTS within individual's overall leave record.

Studying outside of normal working hours

6.9 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

6.9.1 Part time staff attending training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 8.1.

6.9.2 Full time staff attending training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 8.1.

6.9.3 Shift workers or night staff attending training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event.

6.10 Time in lieu should be taken within 3 months of the learning and development activity, provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

6.11 If learning and development essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's rostered rest day, the rest day should be reallocated.

6.12 For personal development, study that is non-essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

6.13 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff. Where research time is granted, this must be requested through the HRPTS system as a study leave request (see paragraph 8.9)

Day and block release.

6.14 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

6.15 Day and block release must be requested as a study leave request through the HRPTS system (see paragraph 8.9).

6.16 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director prior to the manager approving the leave request on the system.

Charitable funds and sponsorship

6.17 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the Application for Approval of Expenditure from Charitable Funds form which is available from the Charitable Funds section, Finance Department, Glendinning House, Belfast. NB: The principles of this policy apply regardless of funding source.

6.18 On approval of the Application for Expenditure from Charitable Funds form, the New Training Request Form must be completed by the applicant referencing the details of the of the approval for expenditure from charitable funds. These details, including the approval date and reference numbers, should be entered in the “Description text box” of the New Training Request Form.

7 Procedure for applying for assistance to study on HRPTS

7.1 The member of staff (applicant) should complete the online 'New Training Request Form' in HRPTS. This form must always be completed *prior* to the learning or development activity being undertaken. Only in exceptional circumstances should this form be completed retrospectively, for example if the activity is required at short notice. The New Training Request Form can be located in the "Appraisals, Learning & Development" area of the Employee Self Service (ESS) screen. When all sections (fields) are fully completed, the applicant must click on the '*submit'* button to ensure the system processes the application to their line manager for consideration (see Appendix 2 for screen completion guidance).

7.2 The manager receives the online Training Request application on the HRPTS system and considers as per policy. The manager approves or rejects the application request by clicking on the appropriate button/icon on screen (see Appendices 2 & 3 for guidance).

7.3 The managers' decision to approve or reject the application will be communicated to the member of staff via a HRPTS system notification. Where an application is being rejected, this must be followed up by the manager in writing (see section 6.4 of this policy and Appendix 4 for further guidance). Where the manager does not agree with some of the details provided by the staff member on the New Training Request Form they should reject it and inform the employee to submit another New Training Request Form with the amended details.

7.4 On approval of the New Training Request Form, the member of staff should;

- book their own activity
- quote the appropriate cost centre to the learning and development provider
- ask the learning and development provider to send the invoice to the BHSCT Finance department for payment
- ensure the learning and development provider is aware they must quote the cost centre code on the invoice

Directorates will meet the costs incurred from within their own budgets. The invoice will be forwarded to the appropriate manager for approval via the Finance Procurement and Logistics (FPL) system. Where a percentage of the total fees are rechargeable to the member of staff, the approving manager will be required to complete the recharging process using the FPM Invoice Request Form through the Trust FPL system (further guidance can be obtained from BHSCT Finance department). Please note;

- all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education
- all invoices relating to commissioned activity for AHP's need to be directed to the AHP Lead

7.5 If travel is required (beyond mileage claims), a Central Travel Booking (Staff) form (see Appendix 7) should be completed and staff requiring travel should follow the procedures as indicated at Appendix 6.

7.6 Payment for courses/conferences will not be processed without the approved Central Travel Booking (CTB) application form. Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

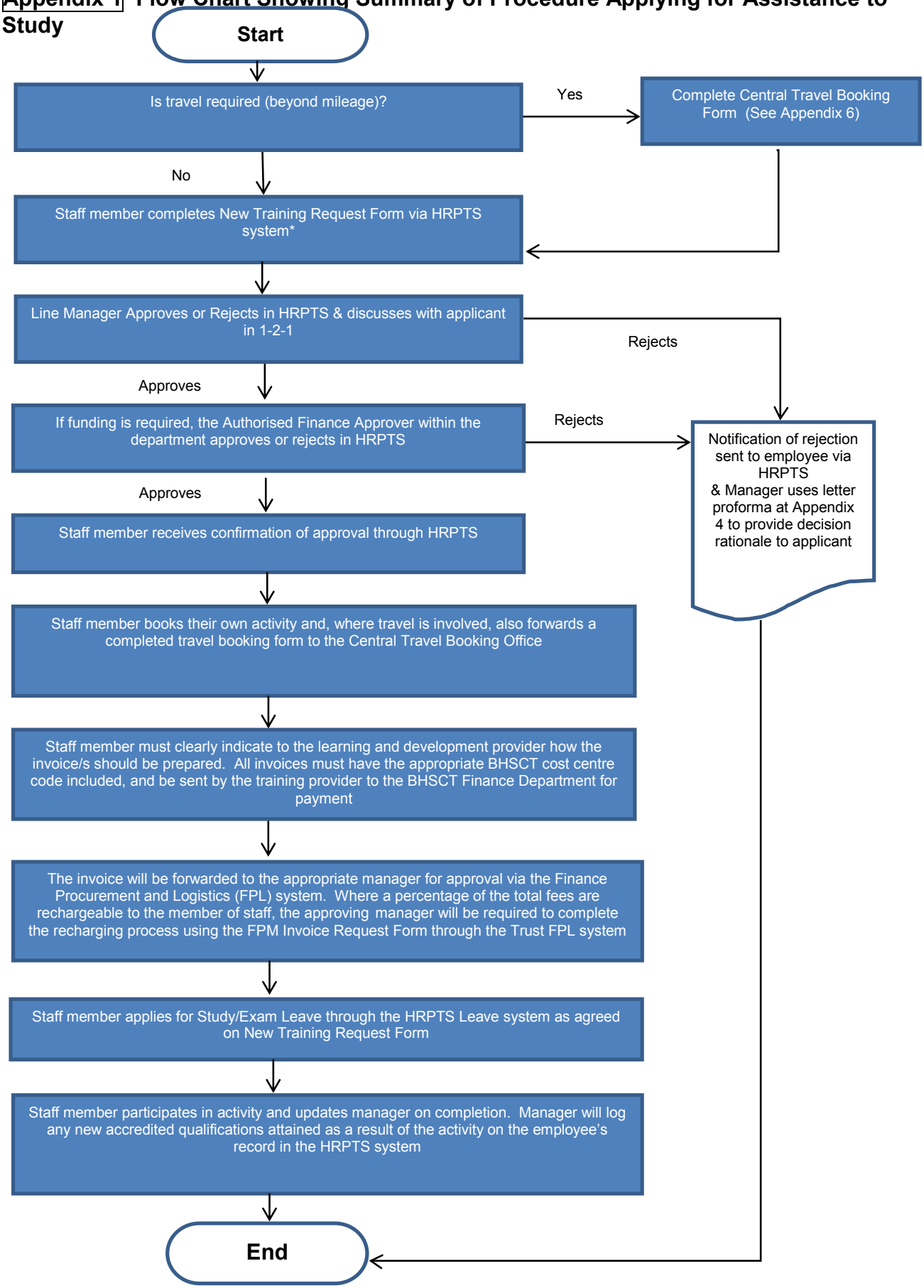
7.7 Managers must retain copies of CTB application forms for their own records.

7.8 As detailed in section 7.8, once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the 'Life and Work Events' area of the Employee Self Service screen) in the HRPTS system.

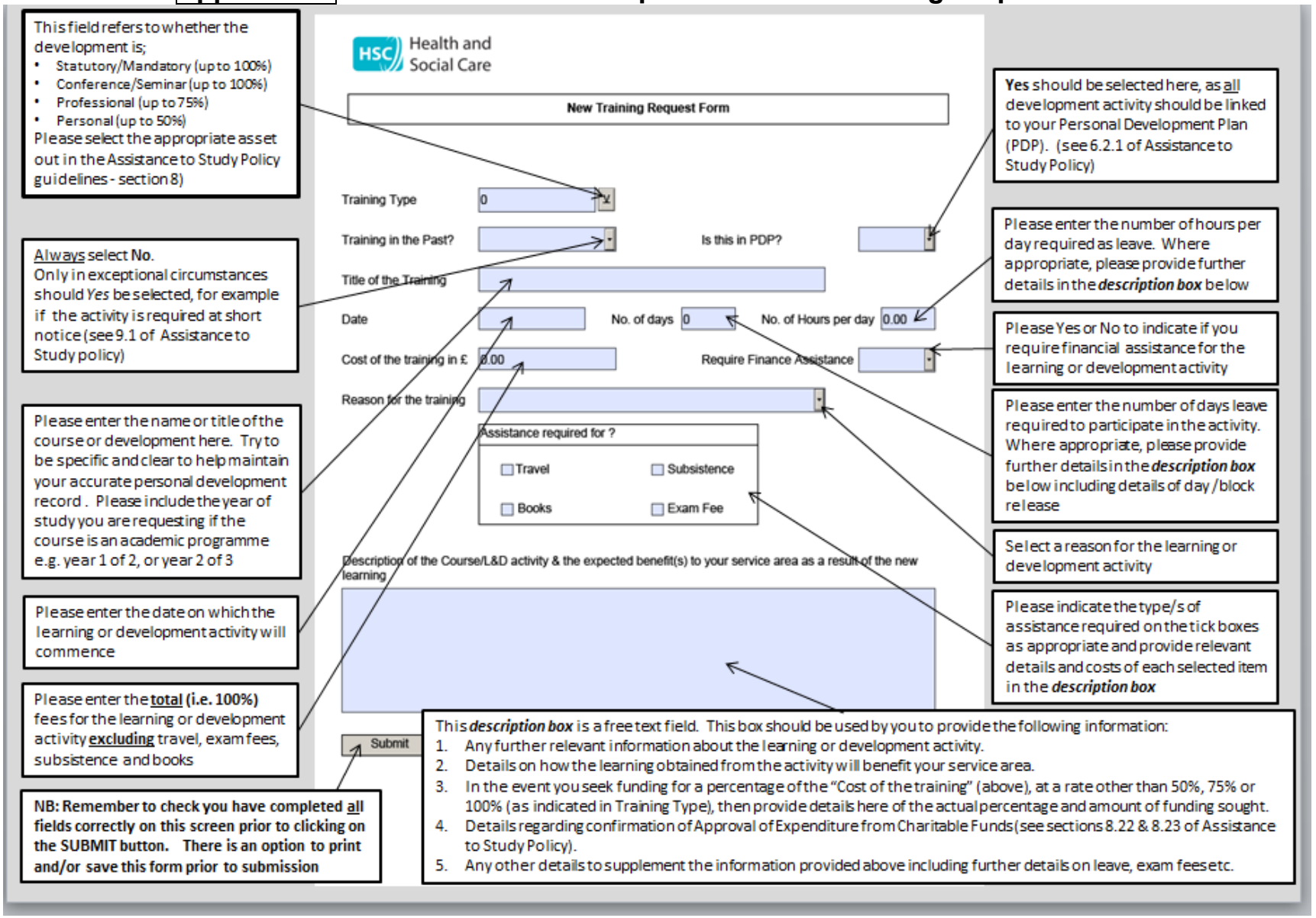
7.9 Managers should update the employee's development record on HRPTS on completion of any accredited qualifications acquired through the Assistance to Study Policy. The record should only be updated by the manager on sight of the original certificates.

7.10 Please refer to Appendix 1 for a flowchart summary of the procedure for applying for assistance to study.

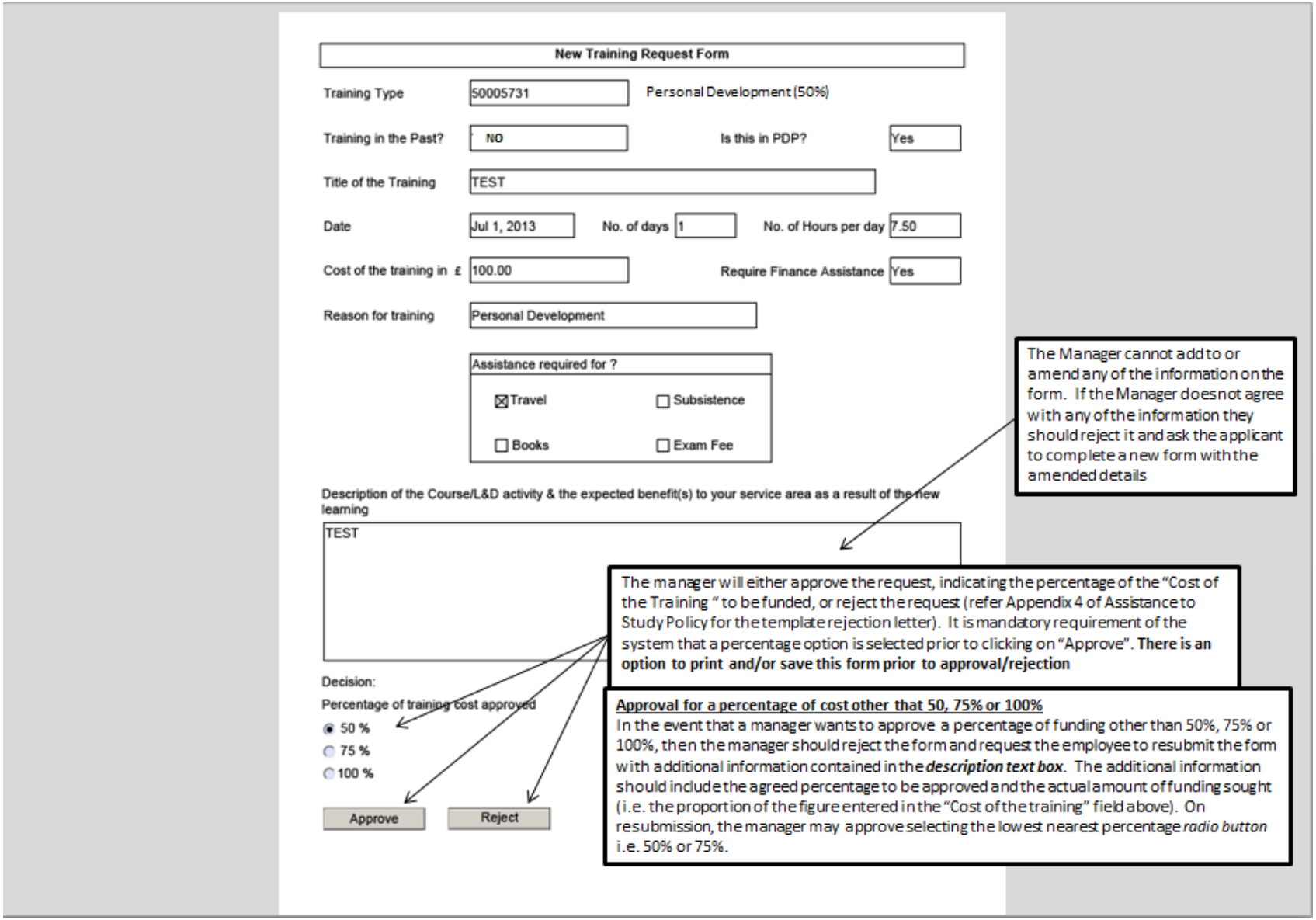
Appendix 1 Flow Chart Showing Summary of Procedure Applying for Assistance to Study



Appendix 2: Guidance on the Completion of New Training Request Form



Appendix 3: New Training Request Form - Manager Approval Guidance



Appendix 4

Template for rejecting an application for assistance to study

Belfast Health and Social Care Trust

APPLICATION FOR ASSISTANCE TO STUDY RESPONSE

Name: _____

Date application received by manager: _____

Dear _____

Thank you for your application for assistance to study, details of which are below;

Name of course/conference/event:
_____
_____

Date(s) of course/conference/event:
_____

Level of funding requested: _____

Travel/expenses applied for: _____
_____

Following consideration of this application, I regret to inform you that your request has been rejected for the following reasons in line with the Assistance to Study Policy;
_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

Appendix 5

Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made via the HRPTS system in the Travel & Expenses area of the Employee Self Service (ESS) screen. Staff should clearly note on their claim what learning and development activity the claim relates to e.g. course of study, conference. This will be considered and authorised online through the appropriate manager.

Where accommodation is required for the member of staff to attend the learning and development activity, this should be booked as per Trust procedure.

If meals are included as part of the learning and development activity (course or conference), staff should not include these in any claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Any approved application requiring authorised travel requisitions must be processed to Trust Finance Department.

Appendix 6

BHSCT Procedure for Booking Staff Travel

Courses and Conferences – staff

Staff wishing to apply to attend courses or conferences must complete the online 'New Training Request Form' screen for assistance to study requests in line with the Belfast Health and Social Care Trust Assistance to Study Policy.

i. Staff requiring travel in connection with their approved application must complete a Central Travel Booking (Staff) form when approval has been received. Once completed the Central Travel Booking (Staff) form should be sent to Finance department as per paragraph vii below. The booking form (see Appendix 7), is available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:
Either
- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) in Finance – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or
- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange a booking with the travel agent on their behalf.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an Application for Approval of Expenditure from Charitable Funds form. A copy of both the Approval of Expenditure form and the Learning and Development activity form must be attached to the CTB booking form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings without this approval.

vi. **In all cases, the form must be approved by a level 3 or level 4 Manager in line with the Trust's Non Stock Authorisation Framework.** A booking/reservation cannot be made for staff if forms are submitted with incomplete information or without the appropriate authorisation. Staff in CTBO will return forms to the applicant if information is incomplete / lacking appropriate authorisation

vii. The fully completed and authorised booking form must be;

Posted to: **Finance Department Central Travel Booking Office**

Or

Scanned / emailed to: Travel.Helpdesk@belfasttrust.hscni.net

viii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above)
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the CTB form. CTBO staff will confirm arrangements with staff prior to booking
- Send all travel details to staff named on the travel request form

Business travel

Where staff members are required to travel by the Trust on business rather than attending a course/conference, please consult the Finance area of the BHSCT Intranet HUB for further information and guidance

http://intranet.belfasttrust.local/directorates/finance/Pages/News/Changes-to-Travel-for-BSTP-Implementation.aspx

Belfast Health and Social Care Trust

Appendix 7

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____ Grade: _____ Staff No: _____

Contact Phone No: _____ Email Address: _____ Cost Centre: _____

Please state purpose of travel: Course / Conference / Business Travel / Escorting Client/Patient
(delete as applicable)

Please ensure all details are correct when submitting this form and it is aligned to the details completed online in your 'New Training Request Form' screen on HRPTS. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a new booking/amendment to a previous booking (*delete as applicable)*

If an amendment, please state previous booking ref and complete updated arrangements. ☐

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (Dietary/Access etc.):

Source of Funding
(If other than service group funding, please detail source of funding e.g. Charitable Funds).

Approved by: _____ **(Service Group Level 3/4 Manager)** _____

Please print **Signed**

_____

Date

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

Belfast Health and Social Care Trust

caring supporting improving together

Reference No: TP033/08

Title:	**Assistance to Study Policy**		
Author(s)	Marina McCarney, Learning and Development Manager		
Ownership:	Jacqui Kennedy, Director of Human Resources & Organisational Development		
Approval by:	Trust Policy Committee Executive Team Meeting	**Approval date:**	06/06/2019 12/06/2019
Operational Date:	June 2019	**Next Review:**	June 2024
Version No.	3.2 **Supercedes**	Version 3.1 – April 2014 - 2017	
Key words:	Study, placement, approval, development		
Links to other policies			

Date	Version	Author	Comments
20/03/2013	2.1	M McCarney	Initial draft considering impact of HRPTS
15/07/2013	2.2	M McCarney C Shannon J McAleer	Revised draft incorporating HRPTS screen input processes
15/08/2013	2.3	M McCarney S Dickey	Revised draft after input from Finance regards updates to 'Travel process'
26/09/2013	2.4	M McCarney C Shannon	Revised draft after consultation
24/03/2014	2.4	C Shannon	Trust Policy Committee approval
11/04/2014	3.0	C Shannon M McCarney	Final version issued
28/10/2014	3.1	M McCarney	Updated documents regards finance and travel paperwork – relating to shared service changes and requirements
06/06/2019	3.2	Peter Kane	Additional information on Travel

1.0 INTRODUCTION / PURPOSE OF POLICY

1.1 Background

Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the core values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

1.2 Purpose

To establish a clear, uniform and comprehensive approach to applying for and approving applications for financial assistance to study, or for any other learning and development activity where there is a direct financial cost to the Trust. This policy also deals with applications which require the individual to take leave in order to undertake learning and development activities.

1.3 Objectives

The policy aims to provide a mechanism to support staff in the acquisition of knowledge, skills and competence required to provide modern, efficient and safe health and social care.

2.0 SCOPE OF THE POLICY

This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3.0 ROLES/RESPONSIBILITIES

The specific responsibilities of Staff, Managers, Human Resources and Finance staff are outlined in the Policy.

4.0 KEY POLICY PRINCIPLES

4.1 Definitions

For the purposes of this policy, the following definitions should be followed:

4.1.1 Learning and development activity – any 'off-the-job' formal education or training programme, related to the individual's Personal Development Plan which carries a direct financial cost to the Trust or a requirement for leave to complete it.

4.1.2 Mandatory - this includes all learning and development activity which the Trust requires a member of staff to undertake to enable that person to fulfil the functions of their role. This type of learning and development activity will be required because it is a professional or statutory requirement to complete it or it is required by the Trust for the individual to undertake it. Further information is available in the BHSCT Statutory and Mandatory Training Policy.

4.2.3 Conferences - those which are either profession or discipline specific and will result in best practice or new learning to be brought back to the Trust. This will also include members of staff invited to present at a conference.

4.2.4 Professional Development - relates to a learning and development activity which is not a mandatory or essential requirement for a job, but is closely related to the individual's role and will add significant value to the service.

4.2.5 Personal Development - is a learning and development activity which is not related to the individual's role but will enhance the individual's long term career progression and personal growth.

4.2 Policy Principles

- All staff require learning and development in their roles
- All learning and development that occurs must be aligned to business need and/or appear on the individual's Personal Development Plan
- Access to learning and development opportunities is subject to service delivery requirements
- Funding and leave is provided at the discretion of the Trust and should not be regarded as a right
- Learning and development must be appropriate to the role of the individual in the organisation and to their career development within the Trust
- All learning and development activity approved through the operation of this policy will be recorded on the staff member's individual training record
- All learning and development must be evaluated through the individual's Personal Development Plan and in line with the Trust's Evaluation Framework

- All staff should be treated equitably with regards applications for assistance to study

- Priority will be given to the completion of statutory and mandatory training

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

This Policy should be disseminated throughout the Trust as it applies to all Belfast Trust staff.

5.2 Resources

Applications for Assistance to Study are made via the new Training Request Form which can be accessed via HRPTS in the "Appraisals, Learning and Development" area of the ESS portal.

5.3 Exceptions

Policies are open to all staff within the Belfast Trust who meet the eligibility criteria.

6.0 MONITORING

HR will monitor this Policy and its use.

7.0 EVIDENCE BASE / REFERENCES

The Policies comply with legislative requirements and good practice.

8.0 CONSULTATION PROCESS

Internal stake-holders such as Staff, Trade Unions and Professional Organisations were consulted in the development of this Policy. The Policy was tabled at the Policy Sub-Committee involving Management Side and Trade Unions Side representatives and approved.

9.0 APPENDICES / ATTACHMENTS

Appendix 1 : Flow Chart Showing Summary of Procedure Applying for Assistance to Study
Appendix 2 : Guidance on the Completion of New Training Request Form
Appendix 3 : New Training Request Form - Manager Approval Guidance
Appendix 4 : Template for rejecting an application for assistance to study
Appendix 5 : Subsistence Rates
Appendix 6 : BHSCT Procedure for Booking Staff Travel
Appendix 7 : Central Travel Booking form
Appendix 8: Application for Approval (Charitable Funds)
Appendix 9: Privacy Notice

10.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.
The outcome of the Equality screening for this policy is:

Major impact ☐
Minor impact ☐
No impact. x

11.0 DATA PROTECTION IMPACT ASSESSMENT

New activities that involve collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 the Trust has to consider the impacts on the privacy of individuals and ways to mitigate against the risks. Where relevant an initial screening exercise should be carried out to ascertain if this policy should be subject to a full impact assessment. The guidance for conducting a Data Protection Impact Assessments (DPIA) can be found via this **link.**
The outcome of the DPIA screening for this policy is:

Not necessary – no personal data involved ☐

A full data protection impact assessment is required ☐

A full data protection impact assessment is not required X

If a full impact assessment is required the author (Project Manager or lead person) should go ahead and begin the process. Colleagues in the Information Governance Team will provide assistance where necessary.

12.0 RURAL IMPACT ASSESSMENTS

From June 2018 the Trust has a legal responsibility to have due regard to rural needs when developing, adopting, implementing or revising policies, strategies and plans, and when designing and delivering public services.
It is your responsibility as policy or service lead to consider the impact of your proposal on people in rural areas – you will need to refer to the shortened rural needs assessment template and summary guidance on the Belfast Trust Intranet. Each Directorate/Division has a Rural Needs Champion who can provide support/assistance in this regard if necessary.

13.0 REASONABLE ADJUSTMENTS ASSESSMENT

Under the Disability Discrimination Act 1995 (as amended), the Trust has a duty to make reasonable adjustments to ensure any barriers disabled people face in gaining and remaining in employment and in accessing and using goods and services are removed or reduced. It is therefore recommended the policy explicitly

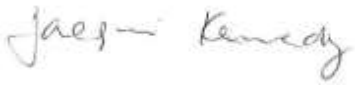
references “reasonable adjustments will be considered for people who are disabled - whether as service users, visitors or employees.

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible director).

Date: __20/06/2019_____

HR Learning & Development / Author



12 June 2019

_____ Date: _____

Name: Jacqui Kennedy

Title: Director of Human Resources & Organisational Development

12 June 2019

_____ Date: _____

Name: Martin Dillon

Title: Chief Executive

Belfast Health and Social Care Trust

caring supporting improving together

ASSISTANCE TO STUDY POLICY

1 Introduction

1.1 Belfast HSC Trust values the contribution of its staff to achieving its five corporate objectives. In recognition of this, Learning and Development has been identified as one of the five values of the organisation and is therefore considered to be a critical and fundamental activity for the Trust, aligned to its service objectives. This policy will underpin the implementation of related Trust strategies and policies, such as the BHSCT Learning and Development Strategy.

1.2 In line with the Trust's Employment Equality and Diversity Plan, Learning and Development activities are open to all staff regardless of their sex; religious beliefs; political opinions; marital status (civil partnership or family statuses); race; age; sexual orientation; whether they are disabled; whether they have undergone, are undergoing or intend to undergo gender reassignment; their working pattern and whether or not they have dependants.

2 Scope

2.1 This policy should be used in relation to any learning and development activity to be undertaken outside of the Trust or which has a direct financial cost to the Trust or requires time away from the workplace to complete. This policy does not apply to internal training or courses run by HSC Leadership Centre or HSC Clinical Education Centre for Nursing & Midwifery and Allied Health Professionals (unless there is a direct fee payable). Registered nurses and midwives should also follow guidance contained in the Framework for the management of Nursing & Midwifery Post-Registration Education Commissioning (2008). Medical and Dental staff have separate arrangements.

3 Aim

3.1 Learning and development is critical to equip staff with the knowledge and skills required to provide the best possible service to the patients and clients of the Trust. The policy aims to provide a mechanism to support staff in this and in the delivery of the Trust's strategic objectives, namely: to provide safe, high quality effective care; to modernise and reform our health and social services; to improve health and wellbeing through partnerships with users and partners; to show leadership and excellence through organisation and workforce development; to make the best use of resources by improving performance and productivity. In addition to this, the policy underpins the Trust's core values of; treating everyone with respect and dignity, displaying openness and trust, being leading edge, maximising learning and development and being accountable. It is also the aim of this policy to support staff in both their professional and career development.

4 Decision Making Criteria

4.1 The following criteria are provided as guidance to both staff and managers as to the type of learning and development activities which are likely to be supported. They have been separated into two parts.

4.2 Part A: Applications must meet both of these requirements:

4.2.1 The learning and development need must have been identified on the individual's Personal Development Plan;

4.2.2 The learning and development need must be in line with at least one of the five Trust Strategic Objectives

4.3 Part B: The following criteria are provided to guide managers in the decision making process. Consideration should be given to:

4.3.1 How approval would impact on service delivery and ability to provide a safe and effective service to patients and clients.

4.3.2 The relevance of the proposed learning and development activity to the individual's job;

4.3.3 Other opportunities available which would gain the same learning outcomes but cost less or have a lesser time commitment;

4.3.4 Whether the staff member has completed all required mandatory training for their role, or is booked to attend the mandatory training and has made every effort to attend it, or if the need is part of the individual's mandatory training;

4.3.5 Any previous learning and development support provided to the individual and whether they have attended this activity previously;

4.3.6 The individual's capacity to commit to undertake the activity;

4.3.7 The numbers of staff applying for the same or similar activity;

4.3.8 If the member of staff had previously applied for the activity but had been rejected due to the number of places or funding available at that time;

4.3.9 The overall length and cost of the activity

4.4 The member of staff will be informed via the Human Resources Payroll Travel Subsistence (HRPTS) system of the manager’s decision to authorise or refuse their application. In cases where an application is refused, the manager should also detail the reasons as to why it has been refused (the template at Appendix 4 can be used for this purpose). The automated system responses should not remove the opportunity for face to face discussion between the manager and applicant (staff member) about the development activity and associated study leave requests. If a member of staff is unhappy with the decision they receive they should attempt to resolve it informally with their line manager and/or next level manager and if no resolution is achieved, the Grievance Procedure may be used.

4.5 When deciding to approve an application for assistance to study, managers should discuss with the member of staff how they will use the learning activity to enhance their work environment and how they will disseminate learning to other members of staff.

5 Continuing Professional Development (CPD)

5.1 In many professions, registering bodies require individual registrants to provide evidence of CPD activity they have undertaken within a defined timeframe. Some registering bodies require their registrants to demonstrate they have completed a certain amount of CPD usually expressed in hours per year. CPD consists of a wide range of activities including, but not exclusively limited to: reflective practice; mentoring; project work in the workplace; on-the-job training; reading; job shadowing; formal education and/or training programmes.

5.2 This policy aims to support staff undertaking learning and development where a formal education or training programme related to their role carries a cost or time implication as per the definitions and decision making criteria provided. Registrants should not expect to receive support for all CPD activity they undertake as it is expected that formal education and/or training will only be a small part of what a registrant would present to their registering body as CPD evidence. It is the responsibility of individual registrants to ensure their CPD evidence meets the requirements of their registering body.

6 Funding entitlements and leave

6.1 Depending on the type of activity applied for and approved by the manager, the following table sets out the maximum funding/entitlements available:

Type of development	Level of funding (registrations, course / exam / conference fees)	Time off to attend study	Costs for resources required e.g. books*	Excess mileage and subsistence
Mandatory	100%	100% Paid time off	All costs covered	100% excess mileage and subsistence rates
Conferences	100%	100% Paid time off	Not applicable (unless they are presenting)	100% excess mileage and subsistence rates
Professional	Up to a maximum of 75%**	100% Paid time off	Up to a maximum of £75	100% excess mileage and subsistence rates
Personal	Up to a maximum of 50%	50% Paid time off	50% of cost up to a maximum of £75	50% excess mileage and subsistence rates

**Please note: it is expected books/resources will be borrowed or bought 2nd hand where possible and where it does not present an infection control risk*
***With the exception of commissioned activity for registered nurses and midwives*

6.2 An application which has a direct cost implication or a requirement for leave from work must be authorised via the New Training Request Form on the HRPTS system by the appropriate level of management (See Appendices 2 & 3).

6.3 Reimbursement;

6.3.1 Except in exceptional circumstances, (for example extenuating personal circumstances which have been discussed with the line manager), staff who fail to complete a programme of study either by withdrawing from the course or failing examination or assessment, will be required to reimburse the Trust.

6.3.2 A member of staff who fails to attend a conference which has been paid for by the Trust will equally be liable to reimburse the Trust.

6.3.3 Staff who resign either during a period of study or within 2 years following the completion of study, will be required to reimburse the Trust. Managers will be expected to be responsible for ensuring staff are aware of this stipulation when approving an application for assistance to study and initiating the process if required. For staff transferring to another NHS, Health and Social Care, or other public or voluntary body or agency, the Trust will not seek reimbursement.

Examinations

6.4 For examinations, staff will be entitled to:

6.4.1 1 day off for preparation per exam up to a maximum of 3 days in any one academic year;

6.4.2 1 day off for an examination lasting more than 2 hours up to a maximum of 3 days in any one academic year;

6.4.3 Half day off for an examination lasting 2 hours or less or where the exam is taken at night/evening up to a maximum of 3 half days in any one academic year.

6.5 Applications for examination leave must be made using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Exam Leave” must be selected from the system drop down menu. Please also provide details of the exam leave in the text box labelled, “New Note”. The system will maintain records of leave granted and records can be accessed by managers and staff.

6.6 No financial aid will be provided for staff required to re-sit examinations unless there are exceptional and extenuating personal circumstances which have been discussed with the line manager. Time can only be granted for re-sit examinations where an individual has not exceeded the entitlements quoted above within the same academic year.

6.7 For Nursing and Midwifery staff who have accessed education or training through the Nursing & Midwifery Post-Registration Education Commissioning programme, programmes of education and training sometimes build examination leave into the

total time required to complete the programme. Where this is the case, staff should follow this rather than the provisions set out in 6.5.

Requirements for Applying for Study Leave in HRPTS

6.8 Once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the Life and Work Events area of the Employee Self Service screen) in HRPTS system. The leave reason named “Study Leave” must be selected from the system drop down menu. Please also provide details of the reason for the leave in the text box labelled, “New Note”.

This application process applies to all learning and education activities that require leave from work.

Time off in lieu which has been accrued as a result of attending learning and development activity outside of scheduled working hours, should be applied for in the same manner as study leave using the “Study Leave” drop down option. Please provide details of the leave and how it was accrued in the text box labelled, “New Note”.

As per table 6.1, requests for personal development carry an entitlement of up to 50% time off to attend study. In such cases, two leave requests must be made via HRPTS e.g. one for 50% of the time as study leave and the remaining 50% as another form of leave request which will be agreed between the individual and the manager, for example, holiday leave or unpaid leave.

As a result of the approved study leave application, a study leave record will be generated in HRPTS within individual’s overall leave record.

Studying outside of normal working hours

6.9 Where statutory or mandatory training critical to the individual's job or professional registration is scheduled outside of normal working hours the following guidance should be applied:

6.9.1 Part time staff attending training or education during hours they would not normally be working at the request of the Trust should receive time in lieu as per the table in 6.1.

6.9.2 Full time staff attending training or education outside of their normal working week at the request of the Trust should receive time in lieu as per the table in 6.1.

6.9.3 Shift workers or night staff attending training or education at the request of the Trust should be granted time in lieu for the hours attended at the education or training event.

6.10 Time in lieu should be taken within 3 months of the learning and development activity, provided the needs of the service can be met. If this is not possible then the hours must be paid. Where hours are paid, they will include any enhancements that would have been paid had the individual worked those hours.

6.11 If learning and development essential to the individual's role or professional registration is attended at the request of the Trust on the member of staff's rostered rest day, the rest day should be reallocated.

6.12 For personal development, study that is non-essential or where the Trust has not requested the member of staff to attend and where classes are held in the evening or at night, time in lieu will not normally be granted.

6.13 It is expected that staff undertaking a course of study will complete coursework in their own time. Where a course of study is based around research the manager may grant paid time consistent with taught courses of a similar academic level and in a way that does not advantage the member of staff against other staff. Where research time is granted, this must be requested through the HRPTS system as a study leave request (see paragraph 6.8)

Day and block release.

6.14 Day release should be agreed with the line manager and must not exceed one whole working day per week during the period of study.

6.15 Day and block release must be requested as a study leave request through the HRPTS system (see paragraph 6.8).

6.16 Block release should be agreed with the line manager and must not exceed 65 days in any leave year. Requests for paid leave in excess of 65 days should be approved by the appropriate Co-Director prior to the manager approving the leave request on the system.

Charitable funds and sponsorship

6.17 For any form of study which is to be funded by either charitable funds or sponsorship from a third party, managers should act in accordance with the Trust's Gifts and Hospitality Policy. Applications being made against charitable funds or sponsorship must be clearly identified on the Application for Approval of Expenditure from Charitable Funds form which is available from the Charitable Funds section, Finance Department, Glendinning House, Belfast.

NB: The principles of this policy apply regardless of funding source.

6.18 On approval of the Application for Expenditure from Charitable Funds form, the New Training Request Form in the L&D screen in HRPTS must be completed by the applicant referencing the details of the of the approval for expenditure from charitable funds. These details, including the approval date and reference numbers, should be entered in the “Description text box” of the New Training Request Form.

7 Travel

7.1 If travel is required (beyond mileage claims), a Central Travel Booking (Staff) form (see Appendix 7) should be completed and staff requiring travel should follow the procedures as indicated at Appendix 6. Staff will be required to sign a disclaimer section on the form to demonstrate and confirm management approval has been authorised on HRPTS.

7.2 Payment for courses/conferences will not be processed without the approved Central Travel Booking (CTB) application form. **Note:** Finance will not pay in excess of set subsistence rates without approval from an appropriate manager on the authorisation framework.

7.3 Managers must retain copies of CTB application forms for their own records.

7.4 The most economical mode of travel should be selected to will allow the member of staff to attend training/study and minimise the time spent away from their workplace.

7.5 Where possible, an overnight stay should only be booked if absolutely necessary to attend training/conference.

7.6 Unless there are exceptional circumstances and with Ministerial approval, no member of staff should travel outside of Ireland or Britain more than five times in a calendar year.

8 Procedure for applying for assistance to study on HRPTS

8.1 The member of staff (applicant) should complete the online 'New Training Request Form' in HRPTS. This form must always be completed *prior* to the learning or development activity being undertaken. Only in exceptional circumstances should this form be completed retrospectively, for example if the activity is required at short notice. The New Training Request Form can be located in the "Appraisals, Learning & Development" area of the Employee Self Service (ESS) screen. When all sections (fields) are fully completed, the applicant must click on the '*submit'* button to ensure the system processes the application to their line manager for consideration (see Appendix 2 for screen completion guidance).

8.2 The manager receives the online Training Request application on the HRPTS system and considers as per policy. The manager approves or rejects the application request by clicking on the appropriate button/icon on screen (see Appendices 2 & 3 for guidance).

8.3 The managers' decision to approve or reject the application will be communicated to the member of staff via a HRPTS system notification. Where an application is being rejected, this must be followed up by the manager in writing (see section 4.4 of this policy and Appendix 4 for further guidance). Where the manager does not agree with some of the details provided by the staff member on the New Training Request Form they should reject it and inform the employee to submit another New Training Request Form with the amended details.

8.4 On approval of the New Training Request Form, the member of staff should;

- book their own study/learning activity
- quote the appropriate Trust cost centre to the learning and development provider
- ask the learning and development provider to send the invoice to the BHSCT Finance department for payment
- ensure the learning and development provider is aware they must quote the cost centre code on the invoice

Directorates will meet the costs incurred from within their own budgets. The invoice will be forwarded to the appropriate manager for approval via the Finance Procurement and Logistics (FPL) system. Where a percentage of the total fees are rechargeable to the member of staff, the approving manager will be required to complete the recharging process using the FPM Invoice Request Form through the Trust FPL system (further guidance can be obtained from BHSCT Finance department). Please note;

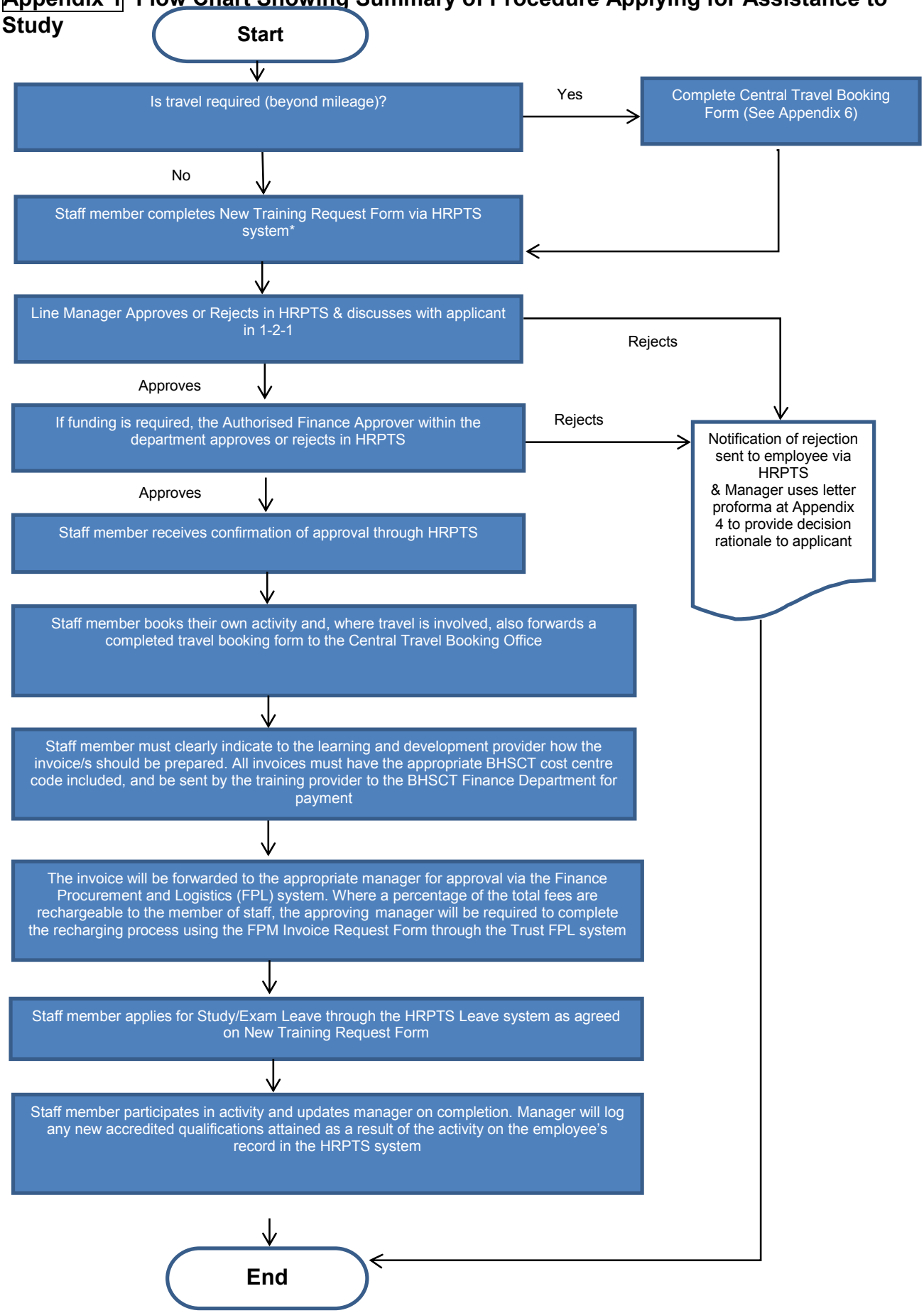
- all invoices relating to commissioned activity for registered nurses & midwives should continue to be sent to the Senior Manager Nursing: Learning, Regulation & Education
- all invoices relating to commissioned activity for AHP's need to be directed to the AHP Lead

8.5 As detailed in section 6.8, once the New Training Request Form has been approved by the manager, the individual must then formally apply for the actual study leave days required using the Leave Request function (located in the 'Life and Work Events' area of the Employee Self Service screen) in the HRPTS system.

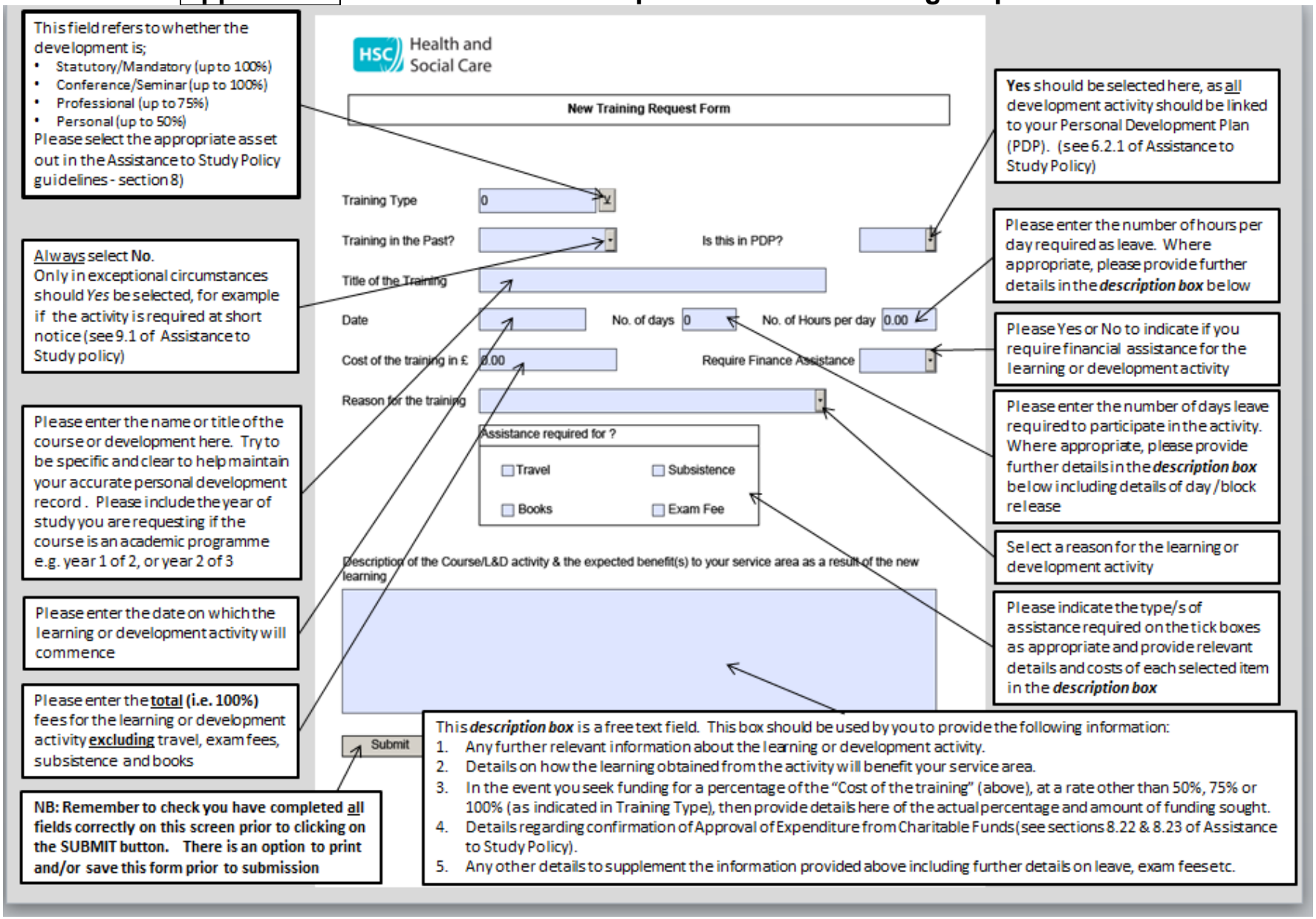
8.6 Managers should update the employee's development record on HRPTS on completion of any accredited qualifications acquired through the Assistance to Study Policy. <u>The record should only be updated by the manager on sight of the original certificates.</u>

8.7 Please refer to Appendix 1 for a flowchart summary of the procedure for applying for assistance to study. If staff have difficulty accessing HRPTS or computer access the manager should complete the request on their behalf.

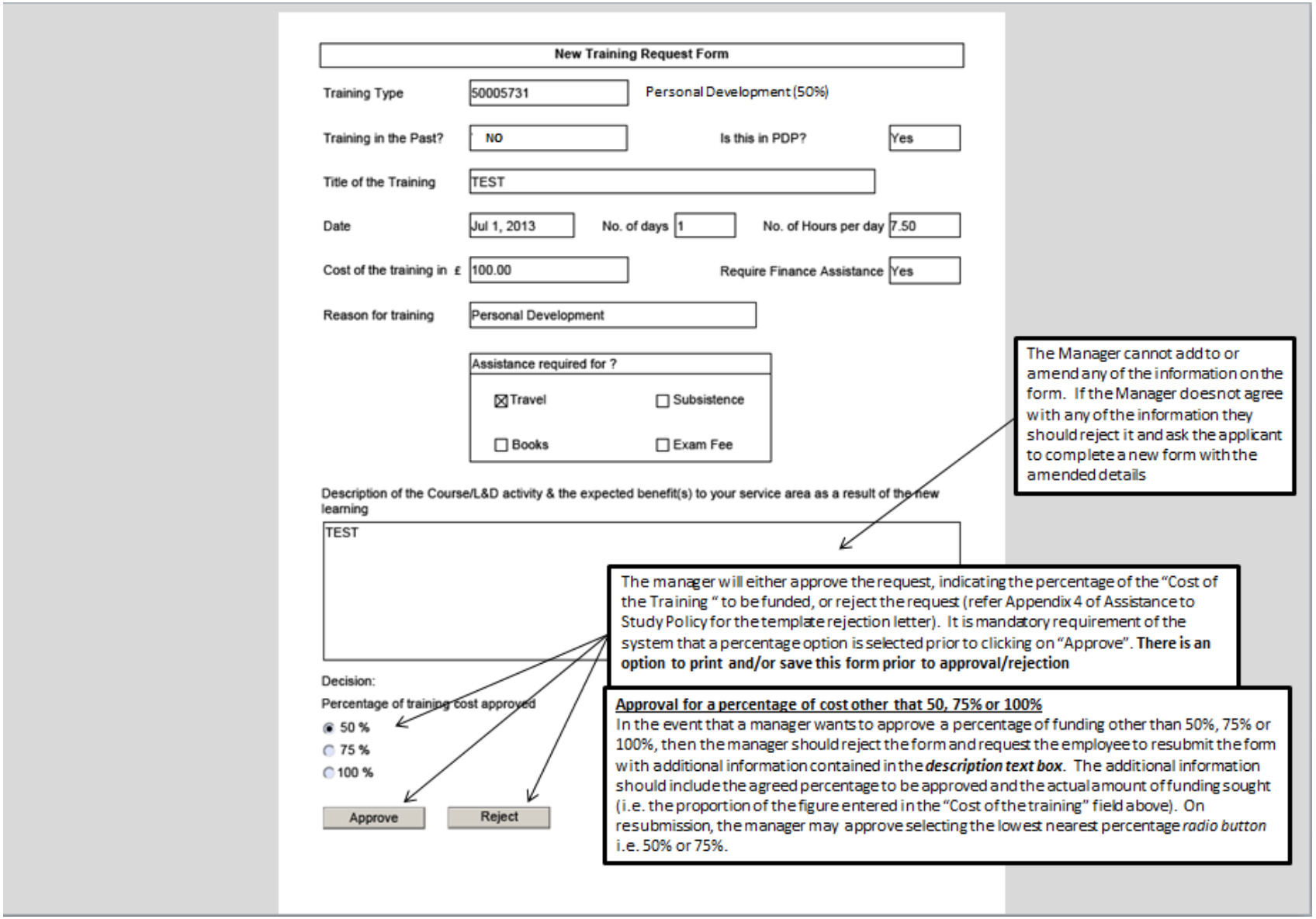
Appendix 1 Flow Chart Showing Summary of Procedure Applying for Assistance to Study



Appendix 2: Guidance on the Completion of New Training Request Form



Appendix 3: New Training Request Form - Manager Approval Guidance



Appendix 4

Template for rejecting an application for assistance to study

Belfast Health and Social Care Trust
caring supporting improving together

APPLICATION FOR ASSISTANCE TO STUDY RESPONSE

Name: _____

Date application received by manager: _____

Dear _____

Thank you for your application for assistance to study, details of which are below;

Name of course/conference/event:
_____
_____

Date(s) of course/conference/event:
_____

Level of funding requested: _____

Travel/expenses applied for: _____
_____

Following consideration of this application, I regret to inform you that your request has been rejected for the following reasons in line with the Assistance to Study Policy;
_____
_____
_____
_____
_____
_____

Yours sincerely

Date: _____

Belfast Health and Social Care Trust
caring supporting improving together

Subsistence Rates

Please refer to Section 18 and Annex N of the Agenda for Change Terms and Conditions.

Claims for mileage or subsistence should be made via the HRPTS system in the Travel & Expenses area of the Employee Self Service (ESS) screen. Staff should clearly note on their claim what learning and development activity the claim relates to e.g. course of study, conference. This will be considered and authorised online through the appropriate manager.

Where accommodation is required for the member of staff to attend the learning and development activity, this should be booked as per Trust procedure.

If meals are included as part of the learning and development activity (course or conference), staff should not include these in any claim for subsistence.

Please note, claims for mileage will only be payable as excess at the public transport rate.

Any approved application requiring authorised travel requisitions must be processed to Trust Finance Department.

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 6

BHSCT Procedure for Booking Staff Travel

Courses and Conferences – staff

Staff wishing to apply to attend courses or conferences must complete the online 'New Training Request Form' screen for assistance to study requests in line with the Belfast Health and Social Care Trust Assistance to Study Policy.

i. Staff requiring travel in connection with their approved application must complete a Central Travel Booking (Staff) form when approval has been received. Once completed the Central Travel Booking (Staff) form should be sent to Finance department as per paragraph vii below. The booking form (see Appendix 7), is available by contacting the email address in paragraph vii.

ii. An application for booking staff travel may be completed in one of two ways:
Either
- By contacting the Trust's contracted travel agent and then confirming details with the Central Travel Booking Office (CTBO) in Finance – please complete Section 2 of the form. Staff may find this option useful particularly where complex travel arrangements are being arranged. Travel will not be booked by the contracted travel agent until the CTBO have asked them to proceed – see (viii) below.

Or
- By providing all details to the CTBO to make arrangements on your behalf – please complete Section 3 of the form.

iii. Staff may contact the Trust's contracted travel agent to discuss travel and accommodation requirements. This information should be completed on the booking form in Section 2.

iv. Alternatively, staff must complete Section 3 to enable CTBO staff to arrange a booking with the travel agent on their behalf.

v. Where funding for attendance at courses/conferences is from the Trust Charitable Funds, staff must also have completed an Application for Approval of Expenditure from Charitable Funds form. A copy of both the Approval of Expenditure form and the Learning and Development activity form must be attached to the CTB booking form and sent to CTBO at the time of the booking. The CTBO staff cannot process/confirm travel bookings without this approval.

vi. **In all cases, the form must be approved by a level 3 or level 4 Manager in line with the Trust's Non Stock Authorisation Framework.** A booking/reservation cannot be made for staff if forms are submitted with incomplete information or without the appropriate authorisation. Staff in

CTBO will return forms to the applicant if information is incomplete / lacking appropriate authorisation

The fully completed and authorised booking form must be;

Posted to: **Finance Department Central Travel Booking Office**

Or

Scanned / emailed to: Travel.Helpdesk@belfasttrust.hscni.net

vii. CTBO staff will:

- Confirm to travel agent that arrangements already made by staff per Section 2 of the form may be booked (as per (ii) above)
- Make travel arrangements with travel agent based on requirements as specified in Section 3 of the CTB form. CTBO staff will confirm arrangements with staff prior to booking
- Send all travel details to staff named on the travel request form

Business travel

Where staff members are required to travel by the Trust on business rather than attending a course/conference, please consult the Finance area of the BHSCT Intranet HUB for further information and guidance

http://intranet.belfasttrust.local/directorates/finance/Pages/News/Changes-to-Travel-for-BSTP-Implementation.aspx

Belfast Health and Social Care Trust
caring supporting improving together

Belfast Health and Social Care Trust

Appendix 7

CENTRAL TRAVEL BOOKING OFFICE STAFF TRAVEL

SECTION 1 - *TO BE COMPLETED BY STAFF*

Name: _____ Grade: _____ Staff No: _____

Contact Phone No: _____ Email Address: _____ Cost Centre: _____

Please state purpose of travel: Course / Conference / Business Travel / Escorting Client/Patient
(delete as applicable)

Please ensure all details are correct when submitting this form and it is aligned to the details completed online in your 'New Training Request Form' screen on HRPTS. Tickets booked may be non-refundable or non-changeable.

Please indicate if this is a new booking/amendment to a previous booking (*delete as applicable)*

If an amendment, please state previous booking ref and complete updated arrangements. ☐

SECTION 2 – TRAVEL ARRANGEMENTS *(arranged by applicant with Trust contracted travel agent)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Other travel and accommodation arrangements made (Please detail)

SECTION 3 – TRAVEL ARRANGEMENTS *(to be arranged by Central Travel Booking Office)*

Outward Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* When do you need to be at your destination?

Return Travel

Date: _____ **Time*:** _____
From: _____ **To:** _____

* What time are you available to make return journey?

Other travel arrangements required? (Please specify)

Is Accommodation required: Yes ☐ No ☐

No. of Nights: _____

City/Town: _____

Single/Twin/Double/Family (***delete as appropriate***)

Please indicate any special requirements (Dietary/Access etc.):

Source of Funding
(If other than service group funding, please detail source of funding e.g. Charitable Funds).

Employee Declaration

By signing this form, I confirm that:

My application to attend this course/conference has been approved by the appropriate manager through the HRPTS system in line with the Trust Assistance to Study policy.

I am responsible for ensuring that the correct level of approval has been obtained before submitting this Central Travel Booking Office form.

Signature:_____ Date:_____

Approved by:

_____ **(Service Group Level ¾ Manager)** _____

Please print **Signed**

_____

Date

This fully completed and authorised booking form must be:
Scanned / e-mailed to: travelbookingoffice@belfasttrust.hscni.net

---

OFFICIAL USE ONLY

Booked by: _____ **Booking Ref:** _____ **Date:** _____

Central file updated: _____

Belfast Health and Social Care Trust
caring supporting improving together

Appendix 8

Belfast Health and Social Care Trust

No: 00000001

Application for Approval of Expenditure from Charitable Funds

Fund Name: _____ **Fund ref:** _____

All expenditure should be procured in line with Trust Policy. Include all costs e.g. installation
Explain how this use meets the charitable purposes

Expenditure details

Supporting documentation attached		Please tick
Goods & Services	Non Stock Requisition/Quotation Expenditure >£5,000 Business case proforma/Management approval	
Research Funding	Research project ref & Certificate of Indemnity	
Salary Recharge	Letters of authorisation	
Expenses Incurred	Original receipts	
Building & Maintenance	Works order	
Maintenance Costs	Supporting documentation inc. value, frequency & term	

Full details of proposed expenditure

Cheque should be made payable to:

If proposed expenditure does not exceed £100 and it is of no financial benefit to the Trust that an official order be raised, please attach original invoice to this document.

Amount applied for excl. VAT £_____ Total £_____

Are you aware of any future costs which may be incurred as a result of this expenditure? □ **YES** □ **NO**

If so, state source of funding for these future costs: Fund Ref: _____ Cost centre: _____

	Signature	Block caps	Band/Grade	Date
Applicant				

In supporting this request, I confirm that the nature of this expenditure meets the objectives of the fund and conforms with the Trust's expenditure criteria for Charitable Funds as stated in the Handbook

	Signature	Block caps	Band/Grade	Date
Advisor signatory				

Employee Declaration

Where applicable, by signing this form I confirm that:

My claim for expenditure from Charitable Funds has been approved by the appropriate manager through the HRPTS system in line with the assistance to study policy

I am responsible for ensuring that the correct level of approval has been obtained before submitting the Charitable Funds form.

Signature: _____ Date: _____

For finance use only	Signature	Block caps	Band/Grade	Date
Authorised by:				

Please note that failure to fully complete this application may result in delays

Registered Charity: No. XT1874

Blank copies of this form can be obtained by contacting: charitablefunds@belfasttrust.hscni.net

Belfast Health and Social Care Trust

caring supporting improving together

Privacy Notice – Why and How HR Use Your Personal Data

The Trust as an employer, collects your personal data for a variety of employment related reasons described in this document. We treat the management of your data and personal information seriously and we therefore store and process it responsibly. Your privacy is extremely important to us and we manage your data securely and within the recommended guidelines and best practice. We will never use your data for any unauthorised purpose, other than those outlined in sections 4 and 5 of this document.

1. Introduction

The law around processing your personal data is set out in the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. For the purposes of Data Protection legislation, the Belfast Health & Social Care Trust is a "Data Controller" (the holder, user and processor) of staff information.
Belfast Health & Social Care Trust collects and processes personal data and sensitive personal data about its staff. This information is used mainly for employment related purposes.
This Privacy Notice has been drawn up in line with the Information Commissioner's Office (ICO) Privacy Notices Code of Practice, to assist the Trust to comply with data protection principles and legislation. It aims to make staff aware of how the Trust processes and uses your personal data.
It should be noted that the Privacy Notice applies to all permanent, temporary, locum and agency staff, volunteers, students on placement and those staff engaged under external contract as sub-contractors. In addition, it applies to those individuals using a range of HR services including Occupational Health.

2. What Types of Information Do We Hold About You?

We hold and process a range of personal data and sensitive personal data mainly for employment related purposes, examples of this are: name, date of birth, address, telephone number, references from previous employers, proof of eligibility to work in the UK, staff number, national insurance number, remuneration details, pension details, Occupational Health information, qualifications, professional registration details and absence information. Data is also held on equality, health and wellbeing, disability, criminal conviction, disciplinary and grievance. This list is not exhaustive.

3. How Do We Collect your Personal Data?

We collect your personal information using computer systems, paper records, telephone calls and e-mails. This can include information you provide in person, on an official form (online or paper) and information that is recorded on CCTV cameras or other digital media in operation within the Trust.

4. What Do We Use Your Personal Data For?

We use the data for various employment purposes, including:

- Payment of salaries, travel, subsistence, sick pay, maternity pay, pension administration etc.;
- Her Majesty's Revenue & Customs (HMRC);
- Management information reports;
- Training and development;
- Staff engagement initiatives;
- Management of sickness absence;
- Management of leave types eg. term time, maternity, employment break;
- Appraisal and revalidation;
- Job Planning;
- Collation of information regarding conduct, health and performance;
- Occupational Health purposes;
- Compliance with legal obligations, for example Police investigations;
- We may also use your data in a way that does not identify you (ie. anonymised) for example for statistics relating to section 3 & 4 in this guide and Statutory Fair Employment Monitoring;

This list is not exhaustive.

5. Sharing Your Information

As an employer, we may need to share your information with certain other organisations: (there may be other occasions where we have a legal duty to share your personal information).

- Business Services Organisation (BSO) Payroll Shared Services Centre (PSSC) & Recruitment Shared Services Centre (RSSC);
- HSC Pensions (BSO);
- Her Majesty's Revenue and Customs (HMRC);
- National Fraud Initiative (NFI);
- Department of Health (DOH) and any relevant Arm's Length Bodies;
- HRPTS Systems Suppliers (HCL AXON);
- Professional Registration Bodies;
- Communication Companies;

- Accredited learning awarding bodies and learning providers (e.g. ProQual, Institute of Leadership & Management)

This list is not exhaustive.

There are a number of reasons why we need to share your information. Some of your information will be shared with BSO for payroll, pension or recruitment purposes. Sometimes we are bound by law to share your information for example for taxation, fraud or law enforcement purposes. Occasionally, we may share some personal information, such as name and address, with communication companies, for important staff communications and engagement purposes, pension changes, staff surveys and exit interviews. Any disclosure of your information will be carried out in a secure manner and in accordance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

6. Security of Information

The Trust has a legal duty to ensure that all personal data relating to staff is held securely. Strict policies and procedures are in place regarding the management of and access to such data. These can be located on the Belfast Trust intranet HUB, or available on request through the Information Governance Department.

7. Retention and Disposal of Staff Information

Staff records are retained in line with the Department of Health's Good Management, Good Records' Retention and Disposal Schedule. This schedule can also be accessed on the Belfast Trust intranet HUB, or available on request through the Information Governance Department.
The Department of Health Retention and Disposal Schedule can be accessed online at:
https://www.gov.uk/government/publications/departmental-records-retention-and-disposals-policy

8. Keeping Your Information Up to Date

It is important that the information we hold about you is up to date. If your personal details change, or are currently inaccurate, it is important that you let us know. You can do this by contacting your Line Manager and or Your HR Team on 028 906 35678.
It is also possible for you to amend some of your personal details on the HRPTS system, through the Employee Self Service (ESS) facility. Please see additional guidance on the Your HR portal on the HUB.

9. The Right to be Forgotten

The General Data Protection Regulation enables individuals to request that the Trust remove certain pieces of information from their file if they feel it is out of date or incorrect. The Trust will consider each individual application on its own merit as

we continue to have a statutory obligation to retain information as per the Trust retention and disposal schedules.

10. Access to your Personal Data

The legislation gives you the right to access or request copies of the information the Trust holds about you. Requests must be made in writing (this can include by e-mail) and you will need to provide a copy of photographic identification such as a driving licence, electoral identity card or passport.
Please send your request to the Trust's Data Protection Office. Contact details can be found below. We will process your request as quickly as possible but you should be aware that the General Data Protection Regulation allows the Trust up to 30 days to respond to your request. This can be extended up to 90 days if your request is complex, however, you will be advised directly if this is the case.

11. Contacting us about your Personal Data

Please contact us if you have any questions about this Privacy Notice or the information we hold about you.
Information Governance Department
1st Floor, Administration Building
Knockbracken Healthcare Park
Saintfield Road
Belfast
BT8 8BH
Tel: 028 9504 6955

12. Who Can I Complain to?

If you are unhappy with any aspect about how we deal with your information, or how we comply with your request for a copy of your information, you can contact:
The Trust's Information Governance Department
or
The Information Commissioner's Office – Northern Ireland
3rd Floor, Cromac Place
Belfast
BT7 2JB